

June 22, 2018

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8011
Baltimore, MD 21244-1850

Re: CMS-1694-P

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2019 Rates; Proposed Quality Reporting Requirements for Specific Providers; Proposed Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims

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Dear Administrator Verma:

On behalf of nearly 38,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on the fiscal year (FY) 2019 Inpatient Prospective Payment System proposed rule. There are numerous proposed policies and requests for information within the rule that have a significant impact on emergency physicians and the patients we serve. Specifically, our comments address the following areas: 1) the request for information on price transparency; 2) proposed modifications to hospital quality performance and reporting programs; 3) proposed changes to the Meaningful Use (Promoting Interoperability) Program; and 4) the request for information regarding interoperability.

Price Transparency

Section 2718(e) of the Public Health Service Act requires hospitals to establish and update a list of the hospital's standard charges for items and services provided by the hospital. While CMS has issued guidance on this requirement in the past, the agency remains concerned that "challenges continue to exist for patients due to insufficient price transparency. Such challenges include patients being surprised by out-of-network bills for physicians, such as anesthesiologists and radiologists, who provide services at in-network hospitals, and patients being surprised by facility fees and physician fees for emergency room visits." Therefore, CMS is proposing to require hospitals to make available a list of their current standard charges via the Internet and update it at least annually. CMS is also considering other potential actions and requests

comments on a number of issues that would help advance their “objective of having hospitals 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 at the hospital, and to enable patients to compare charges for similar services across hospitals.” 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."¹ 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.

Should "standard charges" be defined to mean: average or median rates for the items on the chargemaster; average or median rates for groups of services commonly billed together (such as for an MS-DRG), as determined by the hospital based on its billing patterns; or the average discount off the chargemaster amount across all payers, either for each item on the chargemaster 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? Or is the best measure of a hospital's standard charges its chargemaster?

ACEP believes the best measure of a hospital's charges is from its chargemaster. However, the term "standard charges" is not how these types of charges should be described. Instead, standard charges should be defined as those 'usual and customary' charges routinely billed by hospitals and clinicians for facility charges and professional services regardless of the payor and before any discounts are applied pursuant to governmental policies, charity or indigent discounts, or insurance carrier contracting discounts. The custom and standard trade usage of the terms is "usual and customary charges" instead of "standard charges."

¹ 42 U.S. Code § 300gg-19a

What types of information would be most beneficial to patients, how can hospitals best enable patients to use charge and cost information in their decision-making, and how can CMS and providers 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.

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. Patients should also be provided with reasonable and timely access to in-network physicians for nonemergent care.

In terms of what type of information to provide to patients, we think that the usual and customary physician charge (“U&C charge”) procured from a not-for-profit, independently owned and operated entity is definitely optimal. This entity should offer patients access to 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 stratified, geographically adjusted, and specialty specific. The gold standard for databases is the FAIRHealth² database, 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.³

¹ More information on the FairHealth database is available at <https://www.fairhealthconsumer.org/>.

³ NORC at the University of Chicago, Qualitative Assessment of Databases for Out-of-Network Physician Reimbursement, April 18, 2018.

The mission of FAIRHealth is to provide transparency to the health care and health insurance marketplaces. It was established in 2009 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 the health plans. Known as the “Thomas/Love” class actions brought by the American Medical Association (AMA) and five state medical societies, the major health plans settled 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 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 (DFS regulation) and Connecticut (by statute). 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 stomach ulcer 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. 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 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.

Should health care providers be required to inform patients how much their out-of-pocket costs for a service will be before those patients are furnished that service? What changes would be needed to support greater transparency around patient obligations for their out-of-pocket costs? What can be done to better inform patients of these obligations? Should health care providers 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.

One 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 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.

Should we require health care providers to provide patients with information on what Medicare pays for a particular service performed by a health care provider? If CMS were to finalize a requirement that this information be made available to beneficiaries by health care providers, what changes would need to be made by health care providers? What corresponding regulatory changes would be necessary?

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. In fact, the 2018 Medicare Trustees Report, which was just released on June 5, acknowledges that annual updates for physician reimbursement do not keep pace with the increasing cost of providing physician services. The Trustees believe that, absent a change in the delivery system or future legislative update to physician rates, access to Medicare-participating physicians will become a significant issue in the long term.⁴

⁴ The 2018 Medicare Trustees Report is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2018.pdf>

What is the most appropriate mechanism for CMS to enforce price transparency requirements? Should CMS require hospitals to attest to meeting requirements in the provider agreement or elsewhere? How should CMS assess hospital compliance? Should CMS publicize complaints regarding access to price information or review hospital compliance and post results? What is the most effective way for CMS to publicize information regarding hospitals that fail to comply? Should CMS impose civil money penalties on hospitals that fail to make standard charges publically available as required by section 2718(e) of the Public Health Service Act? Should CMS use a framework similar to the Federal civil penalties under 45 CFR 158.601, et.seq. that apply to issuers that fail to report information and pay rebates related to medical loss ratios, as required by sections 2718(a) and (b) of the Public Health Service Act, or would a different framework be more appropriate?

ACEP acknowledges that the price transparency requirements described in Section 2718(e) of the Public Health Service Act pertain to hospitals and not to physicians and therefore defers to hospitals on this question.

How does Medigap coverage affect patients' understanding of their out-of-pocket costs before they receive care? What challenges do providers face in providing information about out-of-pocket costs to patients with Medigap? What changes would be needed to support providers sharing out-of-pocket cost information with patients that reflects the patient's Medigap coverage? Who is best situated to provide patients with Medigap coverage clear information on their out-of-pocket costs prior to receipt of care? 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 vs. secondary vs. tertiary policies are best described and explained by the health plans as they are adjudicating the claims pursuant to policies and procedures that they have created and have implemented. Emergency physicians often do not know whether a patient's secondary or tertiary policy is a Medigap policy or completely understand the policy's terms and conditions until after claims have been adjudicated 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 and contrary to the Administration's efforts to reduce administrative burden for providers.

Quality Reporting/Performance Programs

CMS is proposing a number of changes to the Hospital Inpatient Quality Reporting (IQR) Program, including a few that directly impact the ED. Specifically, CMS is proposing to eliminate both the chart-abstracted and the electronic clinical quality measure (eCQM) versions of ED-1, Median Time from ED Arrival to ED Departure for Admitted ED Patients Measure. CMS is also proposing to remove the chart-abstracted version of ED-2, the Admit Decision Time to ED Departure Time for Admitted Patients Measure, but retain its eCQM version.

According to the rule, CMS is proposing to completely eliminate ED-1 and retain the eCQM version of ED-2 due to the continued importance of assessing ED boarding times for admitted patients. Although

ED-1 is an important metric for patients, CMS believes that ED-2 has greater clinical significance for quality improvement because it provides more actionable information in that hospitals have greater ability to allocate resources to reducing ED boarding time as opposed to the total length of stay for admitted patients.

ACEP does not support the proposal to remove ED-1 and would encourage CMS to maintain the eCQM versions of both ED-1 and ED-2. First, we note that the Emergency Department Benchmarking Alliance (EDBA), a not-for-profit organization that maintains an independent, unbiased database of ED demographic and performance metrics, has repeatedly considered both these measures as core operational metrics.⁵⁻⁶⁻⁷ The EDBA's database includes information from 1,655 EDs on 69 million patients, and its ED operations and performance definitions are widely referenced.

Second, ACEP believes that is difficult to interpret boarding time (ED-2), without measuring total length of stay for admitted patients (ED-1). The time stamp of "admit decision time" varies by hospital, and therefore comparing ED-2 between hospitals has little meaning without out measuring ED-1.

Furthermore, we believe that there may be potential for gaming by hospitals if just ED-2 is used in the Hospital IQR Program. For example, hospitals hoping to reduce their ED-2 time might pressure emergency physicians to not indicate a *decision* to admit until an inpatient bed is available. If ED-1 is still included, CMS may be able to monitor this practice by assessing how ED-1 increases relative to ED-2. Therefore, we believe that both measures are necessary to ensuring that our patients receive high-quality care and that ED boarding times are appropriate. Finally, keeping both measures in the program should not add any burdens, since hospitals do not have to invest additional financial resources reporting ED-1 and both measures are useful for research purposes.

Meaningful Use (Promoting Interoperability)

CMS is renaming the Medicare and Medicaid EHR Incentive Programs to the Promoting Interoperability (PI) Programs and is proposing a new scoring methodology to include a combination of new measures, as well as the existing Stage 3 measures of the EHR Incentive Program. The proposed program will include a smaller set of four objectives (e-Prescribing, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange) and will be scored based on performance and participation. Under the proposed scoring methodology, which reduces the overall number of required measures from 16 to 6, eligible hospitals and critical access hospitals would be required to report certain measures from each of the four objectives, with performance-based scoring occurring at the individual measure-level. Along with these changes, CMS is maintaining its previously finalized policy to require the use of 2015 Edition CEHRT beginning in CY 2019.

⁵ Welch SJ, Asplin BR, Stone-Griffith S, Davidson SJ, Augustine J, Schuur JD. Emergency Department Operational Metrics, Measures and Definitions: Results of the Second Performance Measures and Benchmarking Summit. *Ann Emerg Med.* 2011 July; 58 (1): 33-40.

⁶ Welch SJ, Asplin BR, Stone-Griffith S, Davidson SJ, Augustine J, Schuur JD. Emergency Department Operations Dictionary: More Results of the Second Performance Measures and Benchmarking Summit. *Acad Emerg Med.* 2011 May;18(5):539-544.

⁷ Wiler JL, Welch S, Pines J, Schuur J, Jouriles N, Stone-Griffith S. Emergency department performance measures updates: proceedings of the 2014 emergency department benchmarking alliance consensus summit. *Acad Emerg Med.* 2015 May; 22(5):542-53.

Overall Strategy

ACEP supports CMS' effort to move the Promoting Interoperability Program for hospitals away from a one-size-fits-all, all-or-nothing scoring system and encourages CMS to continue to pursue additional flexibility under the Promoting Interoperability category of the Merit-based Incentive Payment System (MIPS). Many of our members, as emergency physicians treating patients in EDs, are deemed to be "hospital-based" clinicians under MIPS, and therefore receive an automatic exclusion from the MIPS Promoting Interoperability performance category. However, for our members who do not meet the exclusion threshold or who voluntarily participate in this performance category, we reiterate the ongoing need for objectives and measures that are achievable and, more importantly, relevant across all specialties. To realize the full potential of EHRs, requirements of this category need to be less prescriptive and instead allow for flexible approaches that allow clinicians to incorporate technology into their unique clinical workflows, to mitigate data access and functionality issues that might be unique to their practice, and to use EHRs in a manner that more directly responds to their patients' needs and aligns with their clinical workflow. Clinicians also should not be penalized for actions they cannot control. CMS should ensure that any measures are ones that clinicians are able to attest to without relying on the actions of other individuals (patients, technology, or other providers). ACEP was therefore pleased to see in this rule that CMS proposed to remove certain measures that have proven to be burdensome to hospitals and hopes that the agency will continue to do the same for physicians in the next Quality Payment Program (QPP) proposed rule.

Addition of Two Opioid related measures

CMS proposes to add two new measures to the e-Prescribing objective: Query of Prescription Drug Monitoring Program (PDMP) and Verify Opioid Treatment Agreement, both of which support HHS initiatives related to the prevention and treatment of opioid and substance use disorders. The reporting of these two measures would be optional in 2019, given they may not be fully developed by their health IT vendor or not fully implemented in time for data capture and reporting. Eligible hospitals or critical access hospitals (CAH) are excluded from the measures if they do not have an internal pharmacy that can accept electronic prescriptions for controlled substances and are located within 10 miles of any pharmacy that accepts electronic prescriptions for controlled substances. Beginning with the EHR reporting period in 2020, CMS proposes to require these two measures with an additional exclusion for both measures, given variation in State requirements associated with e-prescribing of controlled substances. The exclusion would provide that any eligible hospital or CAH that could not report on these measures in accordance with applicable state law would be excluded from reporting the measures.

While ACEP believes that PDMPs play an important role in identifying high-risk patients, we recommend that CMS move slowly to allow sufficient time for PDMPs to become fully integrated into clinicians' EHRs and their workflow. We support effective and interoperable PDMPs that push prescription data to emergency physicians, rather than requiring them to separately sign into and pull the data from the PDMP. Currently, not all states have optimally functional PDMPs, resulting in highly variable usability and trustworthiness. Some states have not made commitments to make their PDMPs state-of-the-art and as a result, they are cumbersome, may not contain real time data, and the information can be unreliable. In addition, patients may cross state lines for care and not all states are part of InterConnect, which shares interstate information about dispensed prescriptions.

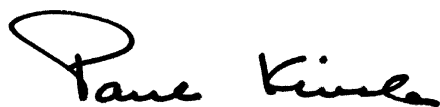
ACEP appreciates that CMS is making this measure optional in 2019. With respect to 2020, we believe that, under only certain conditions, it would be appropriate for CMS to require a hospital or CAH to query a PDPM for at least one Schedule II opioid that is electronically prescribed. These conditions include having the Office of the National Coordinator (ONC) consider adopting new EHR certification criteria that requires EHRs to integrate PDPMs into their existing capabilities. Furthermore, CMS should require all PDPMs to be interoperable and to include certain standards, such as privacy and security protocols that protect patient sensitive information.

Request for Information on Interoperability

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.

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

Sincerely,

A handwritten signature in black ink that reads "Paul D. Kivela". The signature is written in a cursive, flowing style.

Paul D. Kivela, MD, MBA, FACEP
ACEP President