

July 10, 2020

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

CMS-1735-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 2021 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals Proposed Rule

Dear Administrator Verma:

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On behalf of our 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on the fiscal year (FY) 2021 Inpatient Prospective Payment System (IPPS) proposed rule. Our comments are limited to those proposals that affect emergency physicians and the patients we serve.

Price Transparency

In the proposed rule, the Centers for Medicare & Medicaid Services (CMS) is proposing to require hospitals to report their median negotiated inpatient services charges for Medicare Advantage organizations and commercial payors. CMS is seeking comment on potentially using this information to set hospitals' Medicare payment rates in the future.

This proposal, which builds off a price transparency policy that CMS finalized last year, aligns with President Trump's Executive Order called the "Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First." While ACEP supports the Trump Administration's commitment to improving price transparency, we have concerns with the transparency policies that are being implemented. Although we believe patients deserve meaningful information about the price of their healthcare, CMS' policies are 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 eventually lead to anticompetitive behavior by payors 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 its regulations, including the fact that many current provider-payor contracts include non-disclosure agreements regarding the negotiated rate. Even though many of the policies have already been finalized, we ask that CMS refine its overall price transparency strategy

and instead implement policies that are not as burdensome and distributive to the overall health care market.

Proposed Policy Change Related to Medical Residents Affected by Residency Program or Teaching Hospital Closure

CMS is proposing to revise its policies regarding resident transfers when hospitals close and/or announce that their residency programs are ending. Specifically, instead of linking the Medicare temporary funding for the affected residents to the day prior to or the day that the hospital and/or residency program closes, CMS proposes that the determining day would be the day that the closure was publicly announced. Further, CMS proposes to allow funding to be transferred temporarily for residents who are not physically at the closing hospital/closing program, but had intended to train at, or return to train at, the closing hospital. To apply for the temporary increase in the Medicare resident cap, the receiving hospital would have to submit a letter to its Medicare Administrative Contractor (MAC) within 60 days of beginning the training of the displaced residents.

ACEP strongly supports these proposals as a means to protect our residents and provide sufficient funding to teaching hospitals that take in displaced residents. The Emergency Medicine Residents' Association (EMRA), a national association that represents emergency medicine residents, shares our deep support for the proposals. The proposals address some of the issues that came up with the closing last year of Hahnemann University Hospital (HUH) in Philadelphia. For example, when HUH unexpectedly closed, residents had to physically return to the hospital regardless of their individual circumstance and "sign in." Some residents had scheduled time off or were out on rotation and therefore this policy had created an additional burden to the trainees and to the receiving hospitals that wanted to begin to orient available transferring residents. If CMS' proposals had been in place at the time of the HUH closing, it would have been a much smoother transition and experience for residents.

Further, ACEP notes that we fundamentally object to the sale or other commoditization of residency slots and were outraged by the attempted sale of slots after HUH closed. We thank CMS for coming out in opposition to this specific sale, stating that it "would violate Medicare law and regulations," threaten "CMS's ability to carry out its statutory mandate to administer the Medicare program," and that it "gravely misconceives the nature of Medicare funding."¹ Implementing a more comprehensive and sensible policy regarding the treatment of residency slots after a hospital or residency program closes can hopefully help prevent such an unfortunate incident from taking place in the future.

Promoting Interoperability Programs

For calendar year (CY) 2022, CMS proposes an electronic health record (EHR) reporting period of a minimum of any continuous 90-day period for new and returning participants (eligible hospitals and critical access hospitals [CAHs]) in the Medicare Promoting Interoperability Program. ACEP supports a 90-day reporting period for hospitals and CAHs and hopes that CMS will maintain the same reporting period length for other health care providers participating in the Promoting Interoperability (PI) category of the Merit-based Incentive Payment System (MIPS).

Query of Prescription Drug Monitoring Program (PDMP) Measure

CMS is proposing to make the Query of PDMP measure optional again in CY 2021 and eligible for five bonus points. While ACEP believes that PDMPs play an important role in identifying high-risk patients, we agree that CMS should

¹ "Federal judge stays Hahnemann residency sale; St. Chris auction pushed to Thursday" The Philadelphia Inquirer. 16 Sept. 2019. <https://www.inquirer.com/business/health/hahnemann-residencies-sale-stayed-federal-judge-20190916.html>

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 again in 2021. Going forward, we believe that, under only certain conditions, it would be appropriate for CMS to require a hospital or CAH to query a PDMP 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 require EHRs to integrate PDMPs into their existing capabilities. Furthermore, CMS should require all PDMPs to be interoperable and to include certain standards, such as privacy and security protocols that protect patient sensitive information.

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,

A handwritten signature in black ink that reads "William P. Jaquis". The signature is written in a cursive, flowing style.

William P. Jaquis, MD, MSHQS, FACEP

ACEP President