American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

March 9, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

CMS-0057-P

Re: Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program

WASHINGTON, DC OFFICE
901 New York Ave, NW
Suite 515E
Washington DC 20001-4432

202-728-0610
800-320-0610
www.acep.org

Dear Administrator Brooks-LaSure:

On behalf of our 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on the "Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program" proposed rule.

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

Prior Authorization

Background

The Centers for Medicare & Medicaid Services (CMS) includes a number of proposals aimed at streamlining the ways in which certain payors conduct their prior authorization processes. Specifically, CMS is proposing to require all impacted payors to implement and maintain a FHIR Prior Authorization Requirements, Documentation, and Decision API (PARDD API) by calendar year (CY) 2026. The API would automate the prior authorization process (i.e., requiring the process to be electronic). CMS is also proposing to require impacted payors to include a specific reason when they deny a prior authorization request and to send prior authorization decisions within 72 hours for expedited (i.e., urgent) requests and seven calendar days for standard (i.e., non-urgent) requests. CMS, however, is also seeking comment on alternative time frames with shorter turnaround times, for example, 48 hours for expedited requests and five calendar days for standard requests.

ACEP supports the concept of these proposals but has some recommended changes. In all, while we applaud CMS' move to automate the prior authorization process, we believe that any successful solution must address *both the process itself and underlying decision-making criteria*. Without addressing the underlying clinical criteria and prior authorization program policies, even the most streamlined electronic prior authorization system will fail both patients and physicians and simply deliver a faster inappropriate denial. ***We therefore urge CMS to finalize the critical policy reforms around prior authorization that were included in the CY 2024 Part C and Part D proposed rule (87 FR, 79452), as detailed in both the sign-on letter of support signed by the American Medical Association (AMA) and 119 state medical associations and national medical specialty societies, as well as ACEP's individual comments.***

As stated in ACEP's comments on the CY 2024 Part C and Part D proposed rule, in most cases, emergency services are exempt from prior authorization. Every second counts when it comes to treating patients with potentially life-threatening conditions, and therefore, both public and private payors recognize how it unsafe and impracticable it would be to require patients in the emergency department (ED) to receive prior authorization before being able to receive critical services. However, as emergency physicians, we still see how prior authorization can affect the ability of our patients to receive the most appropriate treatment in the most appropriate care setting. We have experienced numerous occasions where patients who are unable to receive services in other care locations because of prior authorization delays or denials come to the ED to receive those services (sometimes at the direction of their provider). The patients come to the ED because they and/or their clinicians recognize that the patients can receive the service without undergoing prior authorization. This clearly is not an appropriate reason for a patient to receive treatment in the ED, but it reflects a fundamental flaw in the health care system resulting from extremely stringent prior authorization protocols.

Prior authorization also affects ED care by contributing to ED "boarding," which is a situation where patients are kept in the ED for hours, days, or longer often due to the lack of available inpatient beds or space in other facilities where the patient could be transferred. Boarding has hit crisis levels, and in November 2022, ACEP and 34 other organizations wrote a letter to President Biden asking his Administration to convene a summit on this issue with all impacted stakeholders so that we can together collaborate on near- and longer-term solutions.

ACEP has heard from many of our members that health plans are requiring prior authorization before a patient can be transferred from the hospital or discharged from the ED to a post-acute facility, like a skilled nursing facility. A key stakeholder in the ED boarding crisis, the American Hospital Association (AHA), pointed out in a March 2022 letter to CMS that the use of prior authorization among Medicare Advantage (MA) plans was clogging up inpatient

beds. As the AHA states, the use of prior authorization is "especially problematic when general acute-care hospital beds have been filled to capacity and while health care providers contend with the demands of vaccine distribution and workforce shortages." The continued use of prior authorization doesn't just clog up inpatient beds, though; it also keeps desperately needed ED beds and even hallway stretchers full – as the AHA notes, it has also "resulted in unintended consequences for patients who were then forced to stay in acute care settings unnecessarily while waiting for health plan administrative processes to authorize the next steps of their care." When ED beds and even hallway stretchers are all full of boarding patients, emergency physicians and nurses must resort to caring for emergency patients right in the waiting room. As one emergency physician described in our November 2022 letter to the President, "Due to these challenges we have fully implemented 'waiting room medicine' […] Nearly 50% of our patient encounters now result in discharge from the waiting room […] it is not at all uncommon to have patients in the waiting room with SarsCoV-2, pending orders for heparin, diltazem, or other vasoactive medications. In the past month we have had SAH [subarachnoid hemorrhage, or brain bleed], Fournier gangrene, hip fractures, septic shock all being treated in the waiting room with no available beds to move them into."

The AHA asked CMS in the letter to prohibit MA plans from conducting prior authorization at least during the remainder of the COVID-19 pandemic. CMS did not adopt such a policy, and hospitals have become even more filled with patients since then, which in turn has caused longer ED wait times and more boarding in the ED, as individuals have to wait for extended periods (multiple days or even longer) for inpatient beds to become available or skilled nursing facility transfer requests to be approved.

Finally, it is important to re-emphasize from our previous comments that ACEP strongly believes that all care delivered in the ED is inherently medically necessary and should not be subject to prior authorization. While prior authorization is prohibited for individuals with emergency medical conditions, payors have routinely questioned whether certain services delivered in the ED are medically necessary. Medical necessity is defined in Medicare as "health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine." There are two existing and long-standing federal laws pertaining to emergency care that require the delivery of diagnostic services and stabilizing care: the Emergency Medical Treatment and Labor Act (EMTALA) and the Prudent Layperson Standard. ***The patient protections and federally required standard of evaluation and stabilization in the ED fundamentally establishes medical necessity***. EMTALA requires hospitals to provide a medical screening examination to every individual who "comes to the emergency department" seeking examination or treatment, and under the Prudent Layperson Standard, payors cannot deny reimbursement to clinicians based on the patient's final diagnosis. An "emergency" versus a "non-emergency" must be determined on a case-by-case basis based on whether the patient's symptoms and complaints reasonably represented to them as a prudent layperson a potential emergency condition. In all, if the prudent layperson standard applies (which happens almost all the time), ACEP strongly believes that the care provided to patients meets the requirements of medical necessity and therefore, should be covered by payors and not subject to prior authorization.

ACEP's Specific Recommended Modifications

Reason for Denial

ACEP supports CMS' proposal to require payors to provide specific denial reasons. However, we believe that CMS

should explicitly require payors to provide a complete list of reasons for denials, including indication of any missing information, the clinical rationale for the adverse determination, the payor's covered alternative treatment (if applicable), and details on appeal rights and process. In the proposed rule, CMS is allowing payors to use codes—either from the designated code list for the X12 278 or proprietary codes/text—to provide denial reasons. These codes and vague explanations could be difficult to interpret. To prevent care delays and subsequent patient harms, we urge CMS to strengthen this provision and specify that impacted payor must provide detailed information about denials to ensure that the information included in prior authorization denials is understandable and outlines clear, actionable next steps.

Timeframes

ACEP appreciates the quick turnaround times included in the rule for approving prior authorization requests. However, we note that, with respect to hospital care that is subject to prior authorization, prior authorization requests could be submitted at any time, seven days a week, twenty-four hours a day. ***Therefore, CMS should consider shortening urgent requests for hospital-related care to 24 hours and standard requests to 48 hours.***

We also urge CMS to specifically state that payors must provide final prior authorization determinations within these timeframes. Sometimes, payors respond to prior authorization requests by requesting additional information. We believe that payors should be able to respond to initial prior authorization requests immediately with trying to require supporting documentation. We therefore urge CMS to further strengthen this proposal by requiring payors to provide a final prior authorization determination within the mandated timelines.

Public Reporting of Prior Authorization Program Metrics

CMS proposes to require payors to publicly report aggregated metrics about their prior authorization programs, including a list of all items and services that require prior authorization, percentage of standard and expedited PAs approved and denied, the percentage of PAs that were approved after appeal, and average and median PA processing time for standard and expedited PA requests. While ACEP believes that aggregated prior authorization data can be useful, we urge CMS to also require reporting of this information at a more granular level, such as by item or service. This level of specificity would allow physicians to evaluate a payor's performance for services relevant in their specialty and prospective patients to assess health plans based on prior authorization metrics related to their clinical condition prior to enrollment. We also strongly urge CMS to make payor public reporting requirements effective immediately upon finalization of this rule. Waiting until 2026, as proposed, would unnecessarily delay CMS' efforts to promote transparency.

New MIPS Promoting Interoperability Requirement

CMS is proposing a new measure for electronic prior authorization for Merit-based Incentive Payment System (MIPS) eligible clinicians under the Promoting Interoperability performance category of MIPS and for eligible hospitals and CAHs under the Medicare Promoting Interoperability Program. To promote PARDD API adoption, implementation, and use among MIPS eligible clinicians, eligible hospitals, and CAHs, CMS is proposing to add a new measure titled "Electronic Prior Authorization" under the Health Information Exchange (HIE) objective in the MIPS Promoting Interoperability performance category and the Medicare Promoting Interoperability Program, beginning with the

performance period/EHR reporting period in calendar year (CY) 2026. For this measure, CMS is proposing that a MIPS eligible clinician, eligible hospital, or CAH must report a numerator and denominator or (if applicable) an exclusion.

ACEP strongly opposes this proposal. Although most emergency physicians are exempt from the Promoting Interoperability Category of MIPS, the addition of this measure would add an extremely unnecessary burden to those emergency physicians who must meet the Promoting Interoperability Category requirements.

This new measure would make clinicians manually track, document, and report every prior authorization request made by a payor so long as the payor has a PARDD API. ***ACEP fundamentally believes that tracking these data elements should be the responsibility of payors, NOT physicians.*** This work is costly, time-consuming, and wastes human resources. It will be excessively challenging for physicians and their staff to track eligible prior authorization requests across mail, fax, and portals and compile the necessary information in a report to CMS. In addition, identifying which prior authorization requests are eligible for the measure will waste time, as it would require medical practices to identify which payors offer FHIR electronic prior authorization (ePA) technology. Yet, CMS is not proposing payors make this information easily accessible to physicians. Thus, medical practices will need to conduct extensive research and call dozens of payors' customer support lines—likely on hold for hours—simply to track down which health plans and insurers meet CMS' ePA denominator requirements. This amount of administrative burden will lead to increased burnout among clinicians and further delays in care.

Patient and Provider Access APIs

In this proposed rule, CMS is proposing to require certain payors (Medicare Advantage organizations, state Medicaid FFS programs, state CHIP FFS programs, Medicaid managed care plans, CHIP managed care entities, and QHP issuers on the FFEs) to include information about prior authorizations in the data that are available through the Patient Access API. In addition, the agency is proposing to require these impacted payors to annually report to CMS certain metrics about patient data requests via the Patient Access API. To improve coordination across the care continuum and movement toward value-based care, CMS is also proposing to require that impacted payors implement and maintain a Provider Access API that, consistent with the technical standards finalized in the CMS Interoperability and Patient Access final rule (85 FR 25558), utilizes HL7 FHIR version 4.0.1. That API can be used to exchange current patient data from payors to providers, including all data classes and data elements included in a standard adopted at 45 CFR 170.213 (currently USCDI version 1), adjudicated claims and encounter data (not including provider remittances and enrollee cost-sharing information), and the patient's prior authorization decisions.

ACEP supports providing patients and clinicians access to information. From an emergency physician perspective, having access to data on a patient could truly help us make what could be life or death decisions. Furthermore, upon ED discharge, enabling all clinicians who are part of the patient's care team to have access to the information from that encounter will improve the whole team's ability to coordinate care for that patient.

Payor to Payor API

In the CMS Interoperability and Patient Access final rule (85 FR 25558), CMS required certain payors (MA organizations, Medicaid managed care plans, CHIP managed care entities, and QHP issuers on the FFEs) to exchange a patient's health data with other payors at the patient's request, beginning on January 1, 2022, or plan years beginning

on or after January 1, 2022. However, after considering stakeholder concerns about implementing the payor to payor data exchange requirement finalized in the CMS Interoperability and Patient Access final rule, CMS announced in a December 10, 2021 Federal Register notification (86 FR 70412) that the agency would not enforce the payor to payor data exchange requirements until further rules are finalized. In this proposed rule, CMS is proposing to rescind its previous payor to payor data exchange requirements and replace them with a new policy. The new proposed policy would require impacted payors (now including Medicaid fee for service programs) to build a Payor to Payor API to facilitate the exchange of patient information between payors, both at a patient's request and at the start of coverage with a new payor. Specifically, that data exchange would include all data classes and data elements included in a standard adopted at 45 CFR 170.213 (currently USCDI version 1), adjudicated claims and encounter data (not including provider remittances and enrollee cost-sharing information), and the patient's prior authorization decisions. ACEP supports this proposal, including the extension to Medicaid fee-for-service—which was not included in the original policy. We agree with CMS that payors are uniquely positioned to collect and aggregate patient data because they typically maintain a relationship with individual patients over a period of time. However, we are concerned that payors will use this requirement as an excuse to impose short, unrealistic turnaround times for physicians to retrieve the information. This could potentially increase administrative costs for physicians, who would be required to update their systems to comply with the demands of the health plans. Furthermore, if physicians cannot comply with payors' new contractual requirements around submitting claims and encounter data, they may be forced out-of-network. We strongly urge CMS to prohibit payors from using these new requirements as an excuse to place additional contractual demands on physicians and other clinicians.

Requests for Information

Accelerating the Adoption of Standards Related to Social Risk Data

CMS requests information on barriers to adopting standards, and opportunities to accelerate the adoption of standards, for social risk data. In recent years, physicians and health plans have begun to recognize the importance of social determinants of health to a patient's overall health. Many interventions help identify barriers to health such as transportation and access to food and housing. One such tool that ACEP supports to help manage care for patients with complex needs is the Collective Medical Technologies' (CMT) Edie™ (a.k.a. PreManage ED) software. Edie™ is an information exchange that provides critical information on patients, such as how many ED visits patients have had in the last year, where they presented, their drug history, other providers who are involved with the patients, and finally, whether there is a patient-specific care management plan that could guide treatment. The platform improves patient care by allowing emergency physicians to make more informed clinical decisions and better direct a patient's follow-up care. It also lowers health care costs through a reduction in redundant tests and through better case management that reduces hospital readmissions. Through an alliance with CMT, ACEP has seen this system mature in approximately 17 states. Washington state, in the first year alone, experienced a 24 percent decrease in opioid prescriptions written from emergency departments, a 14 percent reduction of super-utilizer visits, and state Medicaid savings of more than $32 million.[1]

Some EDs across the country are attempting to create care coordination and case management programs that help improve follow up appointment scheduling from the ED and target social interventions and primary medical care to

[1] https://www.acepnow.com/article/emergency-department-information-exchange-can-help-coordinate-care-highest-utilizers/

high ED utilizers. One such program in Maryland applies mobile technology to use paramedics in a community health worker role to follow up on discharged patients at risk for readmission.[2] Many of these patients are Medicare beneficiaries. Another program in the East Bay, California has a help desk for health-related social needs with four integrated medical-legal partnerships, called Health Advocates, to help patients navigate housing and transportation challenges, immigration challenges, and benefit eligibility.[3]

ACEP is continuing to explore other innovative ways our physicians can help coordinate care for high-risk patients, including through participation in alternative payment models. We have developed a physician-focused payment model (PFPM) called the Acute Unscheduled Care Model (AUCM), which the Physician-Focused Payment Model Technical Advisory Committee (PTAC) recommended to the HHS Secretary for full implementation in 2018. The former HHS Secretary, Alex Azar, in turn recommended that the Center for Medicare & Medicaid Innovation (CMMI) examine how it could incorporate key elements of the AUCM into models that it is developing.

The AUCM provides incentives to participants to safely discharge Medicare beneficiaries from the ED by facilitating and rewarding post discharge care coordination. Under the model, a Medicare beneficiary who presents to the ED will undergo a safe discharge assessment (SDA) concurrent to receiving clinical care to identify socio-economic factors and potential barriers to safe discharge back to the home or community, needs related to care coordination, and additional assistance that may be necessary. If the participating emergency physician, in collaboration with the primary care physician or designated specialist, determines that the patient is a candidate for discharge, the information captured during the SDA will be used to generate unique patient discharge instructions including identifying symptoms that would require rapid reassessment and return to the ED. After the initial ED visit, the patient will receive appropriate follow-up care from the ED physician, his or her primary care physician, and other specialists as needed. ACEP is excited about the infinite possibility this model has in terms of improving care for Medicare beneficiaries, and is eager to work with CMS on implementation.

Overall, however, we need to improve how we document social risk factors in health care. For example, if an emergency physician wanted to know "how many homeless patients did our ED see last year," it would be a real struggle to calculate. That determination of social risk would involve natural-language processing of notes, and maybe social work forms if social work happened to get involved. Important identifiers for so many ED patients like food insecurity and transportation difficulties are not captured in any systematic way.

CMS should consider incentivizing social risk documentation, by either reimbursing more for the care of these patients or could rewarding clinical decision support that made use of this data to warn health care practitioners about discharging these patients without specific resources or support. With respect to payment, ACEP has long supported accounting for social risk factors in Medicare payment programs. ED patients in rural parts of the country, as well as those in urban, medically underserved areas, often have many more social risk factors than those in geographic areas that are better served, with less access to the many resources and community services needed to ensure better health outcomes. Inadequate risk adjustments that do not account for these factors could result in unfair penalties for

[2] For more information on the Maryland Mobile Integrated Health Care Programs, please go to https://www.miemss.org/home/LinkClick.aspx?fileticket=w-K7gG-8teo%3D&tabid=56&portalid=0&mid=1964

[3] For more information on the Health Advocates Program, please go to http://www.levittcenter.org/ed-social-welfare-in-collabor/.

providers that care for the highest acuity low-income patients, creating a perverse incentive that could result in these patients over the long term being further underserved and having their access to care threatened.

Finally, it is important to ensure that any federal agency promoting the collection and exchange of social risk data to think critically around privacy protections for patients and the critical need to engage with the patient while discussing social risk factors, including how such data may be shared, for what purpose, and how the patient can amend such data.

Improving the Electronic Exchange of Information in Medicare Fee-for-Service (FFS)

CMS is interested in public comments regarding how Medicare fee-for-service (FFS) could support improved medical documentation exchange between and among providers, suppliers, and patients as they believe it could enable better care for beneficiaries if covered services are not delayed by inefficiencies.

ACEP is extremely concerned that the presence of this request for information indicates that CMS is planning to expand the use of prior authorization in traditional Medicare. We strongly urge CMS to not proceed with any expansion of prior authorization in traditional Medicare, and as stated above, believe that prior authorization should be categorially prohibited for all ED-related care.

Advancing Interoperability and Improving Prior Authorization Processes for Maternal Health

CMS seeks comment on how using data standards and electronic health records can improve maternal health outcomes. Additionally, the agency asks questions related to how prior authorization can be improved and what special considerations should be given to support data sharing in maternal health care.

ACEP appreciates CMS' dedication to improving maternal health outcomes. Pregnancy and childbirth are complex processes that require careful monitoring and timely interventions to ensure health and safety. Each stage of pregnancy is critically important, and each intervention is time sensitive. Delayed or denied access to necessary care can result in serious adverse outcomes and medical emergencies, including pre-term birth, preeclampsia, hemorrhage, and maternal mortality. Therefore, the use of prior authorization during pregnancy should be removed since prior authorization increases wait time before proper care can be provided, and timely intervention is essential to prevent and/or reduce unwanted maternal health outcomes from conditions such as hypertensive disorders.

However, if prior authorization is continued for maternal care, we strongly urge CMS to treat services related to pregnancy care as urgent and mandate that the prior authorization processing timeframe for a final determination for this care be 24 hours. We also believe that CMS should consider implementing a continuity of care provision for prior authorizations related to pregnancy, especially when there is a change of health plans. Disruptions in care caused by repetitive prior authorization requirements result in adverse outcomes for patients. Therefore, we encourage CMS to protect pregnant women from these harms by instituting requirements that will prevent disruptions in ongoing care, treatment delays, and unanticipated medical costs. Furthermore, we urge CMS to require any and all prior authorization approvals to remain valid for the duration of the pregnancy. Finally, it is critical to include postpartum care in all reforms related to maternal health prior authorization processes, and we urge CMS to require prior authorization approvals for postpartum care to extend 12 months after pregnancy, regardless of a plan change.

Advancing the Trusted Exchange Framework and Common Agreement (TEFCA)

CMS seeks comment on how to encourage providers and payors to enable exchange under TEFCA to make patient information more readily available for access and exchange in a variety of circumstances, with a specific request for comment on how CMS can support enabling exchange under TEFCA and what concerns commenters have about potential requirements related to enabling exchange under TEFCA.

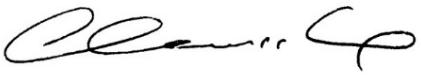
ACEP supports the overall goals of TEFCA but believes that there are many data challenges to address to meet truly enable seamless data exchange. One significant issue for hospital-based clinicians is receiving data on their patient encounters from hospitals. ACEP owns and operates a qualified clinical data registry (QCDR) called the Clinical Emergency Data Registry (CEDR). Unfortunately, there are circumstances where hospitals are simply not sharing EHR data elements with QCDRs that are necessary for MIPS reporting. In fact, a substantial number of emergency physicians that use CEDR to report quality measures are unable to receive any data from their hospitals. Without these data elements, the quality measures cannot be fully calculated and scored. Hospitals may claim that they cannot share the data for privacy and security purposes, but there are no regulations that impede hospitals from doing so. CMS must continue to work with the Office of the National Coordinator for Health Information Technology (ONC) to reduce barriers to exchanging data.

ACEP has also created a next-generation digital platform, the Emergency Medicine Data Institute (EMDI), that currently aggregates about 30 million ED visits annually, and projects this to expand to more than 75 million within five years. But even with our current volume, there are numerous opportunities to provide public health surveillance ranging from product safety, disease management trends, adverse drug event (ADE) surveillance, opioid overdose, and emerging biological threats. Getting the cooperation of hospitals to share data at all or at a reasonable cost is a major barrier to these vital activities. CMS must create appropriate incentives for hospitals to both cooperate and provide data to data aggregators such as ACEP's Emergency Medicine Data Institute. Doing so would help advance the goals of TEFCA.

Finally, there are many burdens for data providers. Creating a data feed (FHIR standard or otherwise) has intrinsic costs. There are other barriers, such as security assessment and compliance with the Health Insurance Portability and Accountability Act (HIPAA). If CMS could create a program by which data aggregators such as ACEP's Emergency Medicine Data Institute could be certified once as being secured and HIPAA compliant, data suppliers could then be required to accept it without an additional burdensome security assessment, removing a major challenge for all parties involved.

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

Sincerely,



Christopher S. Kang, MD, FACEP

ACEP President