American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

January 4, 2021

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8016
Baltimore, MD 21244-8016

CMS-9123-P

Re: Medicaid Program; Patient Protection and Affordable Care Act; Reducing Provider and Patient Burden by Improving Prior Authorization Processes, and Promoting Patients' Electronic Access to Health Information for Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, and Issuers of Qualified Health Plans on the Federally-facilitated Exchanges; Health Information Technology Standards and Implementation Specifications 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 a Centers for Medicare & Medicaid Services (CMS) and Office of the National Coordinator for Health Information Technology (ONC) proposed rule that aims to improve the electronic exchange of health care data.

ACEP supports the Trump 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 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.

ACEP believes that this proposed rule, which builds off of the Interoperability and Patient Access final rule, includes some important provisions that will further reduce information barriers and improve access to data. Our comments on the rule

are limited to those proposals and requests for information that impact emergency physicians and the patients we serve.

Provider Access APIs

CMS is proposing to require certain payors, including Medicaid and CHIP managed care plans, state Medicaid and CHIP fee-for-service programs, and Qualified Health Plans (QHP) issuers on the Federally-facilitated Exchanges (FFEs)—but not Medicare Advantage plans—to build and maintain a Provider Access application programming interface (API) for payor-to-provider data sharing of claims and encounter data starting January 1, 2023. The specific information shared would include a sub-set of clinical data as defined in the U.S. Core Data for Interoperability (USCDI) version 1, and pending and active prior authorization decisions for both individual patient requests and groups of patients. ACEP supports providing clinicians access to this information. Having access to data on a patient could truly help emergency physicians 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.

Prior Authorization Processes

CMS includes a number of proposals aimed at streamlining the ways in which certain payors conduct their prior authorization processes. 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 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 are aware of occasions where patients are unable to receive timely services in the appropriate care setting because of a prior authorization delay or denial and come to the ED (sometimes at the direction of their provider) in an effort to expedite necessary care. Unreasonable delays in routine community-based care can at times escalate into a true emergency, so patients have no other choice but to seek care in an ED. We believe this reflects a fundamental flaw in the health care system often from stringent prior authorization protocols and/or protracted processes. Therefore, while ACEP recommends that CMS adopt these proposals, we also believe the agency should do even more to streamline and automate prior authorization processes in general and include Medicare Advantage plans—which are not addressed in this rule.

Methods for Enabling Patients and Providers to Control Sharing of Health Information

CMS is seeking comment on the role that patients and providers wish to have in controlling the sharing of patient health information. CMS also seeks comment on how to share sensitive health information, such as data under 42 CFR Part 2. In general, ACEP supports policies that would provide patients and physicians the ability to selectively control sharing of data, including the ability to select which data elements from a medical record are shared, when, and with whom. While ACEP cannot comment on all the circumstances where providers and patients should be able to dictate how and what information is shared, with respect to emergency care, ACEP believes that, in general, the sharing of information in the emergency setting for care coordination or other treatment purposes can truly benefit the patient. Having more information about our patients helps us understand not only the underlying factors that might be contributing to an acute medical condition, but also what may be the best treatment option for that patient.

If CMS were to institute policies around data sharing in the emergency setting, it should consider specific circumstances where the sharing of data may not be appropriate or even possible. Some considerations that CMS should factor into such a policy include:

- Patient preference: There are times that a patient may have good reason not to want certain sensitive information shared between providers, even during an emergency. Emergency physicians may, as appropriate, talk to these patients about the benefits of sharing data for treatment purposes.
- Security concerns: Emergency physicians have an ethical and legal responsibility to protect patients' information. If an emergency physician feels that either his or her electronic system or that of the other provider who is exchanging data is not secure, he or she may not feel comfortable either transmitting or receiving data on a patient.
- Natural or man-made disaster: Physicians may not have access to data during and following natural or man-made disasters and would thus be unable to send this information, even for treatment purposes. Thus, any policy CMS institutes must account for these types of emergencies.

Another important issue to consider for emergency care is the timeframe within which data should be shared with the treating emergency practitioner. Emergency physicians provide care to patients around the clock and often have a critical need for patient medical records outside of usual business hours. We understand that many (if not most) community-based care settings are not staffed to provide manual access to medical records during off-hours. However, at the same time, we must consider the consequences of not vital information available during a time of critical need. We believe the technology exists to once and for all stop relying on manual medical records retrieval and move towards online secure automated retrieval.

With respect to 42 CFR Part 2, one of ACEP's top priorities is to ensure that patients with substance abuse disorder (SUD) receive timely and appropriate care. We are working to help reduce the stigma associated with SUD, which we believe impedes access to care and treatment of the disease. At the same time, it is essential to guarantee that the privacy and security of our patients' data are protected at all times. We note that, under the current 42 CFR Part 2 regulations, there is an exception built in for emergency services. Specifically, information can be disclosed to medical personnel to the extent necessary to meet a bona fide medical emergency in which the patient's prior informed consent cannot be obtained.

Accelerating the Adoption of Standards Related to Social Risk Data

CMS requests information on barriers to adopting standards and opportunities to accelerate adoption of standards, related to social risk data. In recent years, providers 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 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. The HHS Secretary 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 HHS 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

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[1] https://www.acepnow.com/article/emergency-department-information-exchange-can-help-coordinate-care-highest-utilizers/2/

[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.

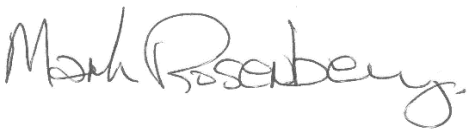
Finally, it is important to ensure that any federal agency promoting the collection and exchange of social risk data to think critically around privacy protections for patients and the critical need to engage with the patient while discussing social risk factors, including how such data may be shared,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

Reducing the Use of Fax Machines for Health Care Data Exchange

CMS is seeking comment on how it can reduce the use of facsimile (fax) technology across programs. ACEP agrees with CMS that reducing or even eliminating the use of faxes to transmit health care information should be a priority. While faxes are being employed less and less in EDs across the country, they are still used occasionally to transmit some information, including laboratory results and discharge documents. Transmitting all this information electronically would not only improve efficiency (which is essential during medical emergencies) but also patient safety—as it would be easier to track patient data and ensure that all relevant information is accurately entered into a patient's EHR. As we fully transition away from the use of faxes, we encourage CMS to help small and/or rural practices adopt the technology and systems needed in order to stop relying on manual and legacy methods of data sharing.

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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