September 11, 2023

The Honorable Chiquita Brooks-LaSure   **CMS–1786–P**
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8016
Baltimore, MD 21244-8016

Re: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; etc.

Dear Administrator Brooks-LaSure:

On behalf of the nearly 40,000 members of the American College of Emergency Physicians (ACEP), we appreciate the opportunity to comment on the Center for Medicare & Medicaid Services' (CMS') Calendar Year (CY) 2024 Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) payment system proposed rule.

Our comments are focused on the proposals that have a significant impact on emergency physicians and the patients we serve.

Hospital OQR Program Quality Measures

Proposed Removal of the Left Without Being Seen (LWBS) Measure Beginning with the CY 2024 Hospital Outpatient Quality Reporting (OQR) Period

The LWBS measure was initially endorsed by a consensus-based entity (CBE) in 2008. This process measure assesses the percent of patients who leave the emergency department (ED) without being evaluated by a physician, advanced practice nurse, or physician's assistant. CMS' rationale for adopting the LWBS measure was that patients leaving without being seen was an indicator of ED overcrowding (75 FR 72089).

CMS continued to retain the LWBS measure over the years since because data showed variation/gap in performance and improvement. However, over the last few years, CMS asserts that its routine measure monitoring and evaluation indicated: (1) limited evidence linking the measure to improved patient outcomes; (2) the assertion that increased LWBS rates may reflect poor access to timely clinic-based care rather than intrinsic systemic issues within the ED; and (3) unintended effects on LWBS rates caused by other policies, programs, and initiatives may lead to skewed measure performance. CMS recognizes that LWBS performance issues could be due to inefficient patient flow in the ED for a variety of reasons or due to insufficient community resources, which result in

higher ED patient volumes that lead to long wait times and patients deciding to leave without being seen. CMS claims that the reasons these patients visit the ED are often not serious enough to warrant them waiting in the ED waiting room for long periods if the ED is crowded. Additionally, CMS does not believe that the LWBS measure provides enough specificity to give value because it does not provide granularity for actionable meaningful data toward quality improvement. Therefore, CMS is proposing to remove the measure, and **ACEP strongly opposes this action.**

This is not the first time that CMS has decided to eliminate an important measure regarding ED overcrowding, wait times, and "boarding." In the Fiscal Year (FY) 2022 Inpatient Prospective Payment System (IPPS) final rule, CMS eliminated ED-2, the Admit Decision Time to ED Departure Time for Admitted Patients measure, starting in 2024. ACEP strongly opposed the removal of this measure as it was a specific measure capturing ED boarding. ED boarding is a concept where patients are held in the ED awaiting admission when there are no inpatient beds available, or, if needing transfer, awaiting space to become available externally such as in a psychiatric facility or skilled nursing facility. While the causes of ED boarding are multifactorial, unprecedented and rising staffing shortages throughout the health care system have recently brought this issue to a crisis point, further spiraling the stress and burnout driving the current exodus of excellent physicians, nurses, and other health care professionals. In November 2021, ACEP and 34 other organizations sent a letter to the White House asking the President to convene a summit on this issue with all impacted stakeholders so that we could together collaborate on near- and longer-term solutions. We still have not received a formal response to the letter.

Although ED wait times and boarding are different concepts, they both reflect the overall issue of ED overcrowding, and LWBS rates have risen sharply in recent years,[1] just as boarding rates have—making it all the more important to keep tracking and reporting this important data. As well, research indicates that boarding reduces the throughput of nonboarded patients at a ratio of approximately 4:1, thereby directly impacting LWBS rates.[2] Thus, it is essential to measure *both* elements of this monumental problem. Numerous studies have shown that ED overcrowding, which longer LWBS rates signify, negatively impacts patient outcomes.[3,4,5,6] CMS' proposal to remove the LWBS measure would greatly reduce the ability to monitor ED wait times and to therefore create and implement evidence-based solutions.

We also take issue with CMS' assertion that the reasons patients who left without being seen came to the ED for care were often not serious enough to warrant them waiting in the ED waiting room for long periods. Patients don't come to the ED with a known diagnosis, only symptoms. By law, 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. As emergency physicians, we often ourselves cannot

[1] Janke AT, Melnick ER, Venkatesh AK. Monthly Rates of Patients Who Left Before Accessing Care in US Emergency Departments, 2017-2021. JAMA Netw Open. 2022;5(9):e2233708. doi:10.1001/jamanetworkopen.2022.33708
[2] Napoli, Anthony & Ali, Shihab & Baird, Janette & Jouriles, Nick. (2022). A Quantitative Assessment of Emergency Department Boarding and its Association with Decreases in Operational Efficiency: A Multicenter Nationwide Study. Academic Emergency Medicine. 29. 10.1111/acem.14560.
[3] Richardson DB. Increase in patient mortality at 10 days associated with emergency department overcrowding. Med J Aust. 2006;184:213-216.
[4] Verelst S, Wouters P, Gillet J-B, Van den Berghe G. Emergency Department Crowding in Relation to In-hospital Adverse Medical Events: A Large Prospective Observational Cohort Study. JEM. 2015;49(6):949-961. doi:10.1016/j.jemermed.2015.05.034.
[5] Sprivulis PC, Da Silva JA, Jacobs IG, et al. The association between hospital overcrowding and mortality among patients admitted via Western Australian emergency departments. Med J Aust. 2006;184:208-212.
[6] Bernstein SL, Aronsky D, Duseja R, et al. The effect of emergency department crowding on clinically oriented outcomes. Acad Emerg Med. 2008;16:1-10.

differentiate just based on presenting symptoms when a patient first comes to our ED whether they are experiencing an emergent or nonemergent condition. Many conditions, both minor and life-threatening, share very similar symptoms, and we frequently must do a full work-up and exam, sometimes with additional diagnostic tools, before it becomes clear what the ultimate diagnosis is. In fact, a 2013 peer-reviewed study published in JAMA[7] of over 34,000 ED visits found that although only 6.3% of visits were determined to have primary care-treatable diagnoses based on discharge diagnosis, the chief complaints reported for these ED visits were the same chief complaints reported for 88.7% of all ED visits. Of these visits, 11.1% were identified as needing immediate or emergency care; 12.5% required hospital admission; and 3.4% of admitted patients went directly from the ED to the operating room. Another study found that 46% of patients who left prior to physician evaluation were in need of immediate medical attention, 11% were hospitalized within the next week, and three patients required emergency surgery.[8] Even if a condition could have been potentially treated in another setting, the compounded effects of delayed care on these conditions may still exceed the savings. When patients have been asked why they walked out of an ED, one reason cited was that they didn't feel well enough to wait any longer[9] – in other words, patients might leave because they are *too* sick to stay, not because they weren't sick enough. In sum, we cannot presume that the only reason patients left without being seen was because they didn't need to be in the emergency department to begin with.

Given all of these factors, the removal of the LWBS measure—the second measure CMS would remove related to ED boarding and overcrowding—would send an even stronger signal that CMS does not recognize or acknowledge the seriousness of this issue and is indifferent to the negative effects that ED wait times, overcrowding, and boarding have on patient care and patient outcomes. **We strongly urge CMS to reconsider this proposal.**

<u>Public Reporting Median Time for Discharged ED Patients-Transfer Patients and Median Time for Discharged ED Patients-Overall Rate</u>

The Median Time from ED Arrival to ED Departure for Discharged ED Patients (Median Time for Discharged ED Patients), a chart-abstracted measure that evaluates the time between the arrival to and departure from the ED, also known as ED throughput time, is calculated in stratified subsections for certain types of patients. Currently, two strata are publicly reported: Median Time for Discharged ED Patients-Reported Measure, which excludes psychiatric/mental health and transferred patients; and Median Time for Discharged ED Patients-Psychiatric/Mental Health Patients, which includes information only for psychiatric/mental health patients. CMS is now proposing to publicly report measure data for all strata in the measure, including Median Time for Discharged ED Patients-Transfer Patients and Median Time for Discharged ED Patients-Overall Rate, on their Compare site. The agency seeks comment on this proposal.

ACEP supports the concept of providing quality-related information to consumers. However, we are concerned that public reporting of this data could discourage patients from coming to the ED when they have a medical emergency because of extended throughput times that may be due to factors outside of emergency physicians' and the ED's

[7] Raven MC, Lowe RA, Maselli J, Hsia RY. Comparison of presenting complaint vs discharge diagnosis for identifying " nonemergency" emergency department visits. JAMA. 2013 Mar 20;309(11):1145-53. doi: 10.1001/jama.2013.1948. PMID: 23512061; PMCID: PMC3711676.
[8] Baker DW, Stevens CD, Brook RH. Patients who leave a public hospital emergency department without being seen by a physician. Causes and consequences. JAMA. 1991;266:1085-90.
[9] Pines JM, Hollander JE. Emergency department crowding is associated with poor care for patients with severe pain. Ann Emerg Med. 2008;51:1-5.

control. Customarily, patients who arrive at the ED via walk-in are checked in and either directed to a treatment area or the waiting room to wait until space is available, depending on the severity of illness. Once space becomes available, they are taken back into the treatment area for completion of the clinical assessment and any needed treatment. A decision is then made that the patient is either well enough to go home or requires admission to the hospital for continued treatment. Inpatient beds traditionally require both a physical bed space (patient room) and nurses to care for that patient. Unlike in the ED, most hospitals have ratios of nurses to patients for inpatient beds to promote quality of care and patient safety that are set by state laws, regulatory agencies, and accrediting bodies. If there are no available (staffed) beds within the specific unit to which the patient needs transferring, the patient must wait, or be "boarded" in the ED, often for hours, sometimes days or even weeks. The same issue of required staffing ratios holds true for transfer outside the facility, such as to an inpatient psychiatric facility or a skilled nursing facility. EDs also see the most urgent patients first, not by the order in which they arrived. Therefore, the measure may not accurately reflect the efficacy of the ED itself but rather is affected by outside influences.

Hospital OQR Program Quality Measure Topics for Potential Future Consideration

Solicitation of Comments on Patient and Workforce Safety as a Measurement Topic Area in the Hospital OQR Program

CMS seeks public comment on patient and workforce safety measures to fulfill their objective to promote safety by developing measures that assess and hold health care systems accountable to keep individuals safe through preventative and treatment processes. Thus, CMS is requesting input from interested parties on the following topics: (1) safety outcome priorities specific to settings, services, transitions and transfers, and access to care; (2) general cross-outpatient setting outcomes; (3) individual harms, including methodological approaches to patient identification and data collection, technological-derived harm, and use of electronic resources to mitigate potential for harm; and (4) workforce safety.

ACEP has worked extensively to create and establish policies that promote the highest standard of patient safety. We continuously reevaluate best practices for the ED to fulfill its critical safety net functions to the community. However, as described above, one of the biggest threats to patient safety, ED boarding, is often due to circumstances outside of the ED's control. Hospitals bear the responsibility of ensuring the prompt transfer of admitted patients to inpatient units as soon as the treating emergency physician has made the disposition decision. Therefore, hospitals should develop appropriate mechanisms to facilitate availability of inpatient beds, nursing staff, and support personnel to meet the increased patient needs in the event of ED boarding. Patients should not receive a lower quality of care because of inefficient hospital flow systems, staff shortages, insufficient beds, ineffective triage systems, or any other failure of planning that results in ED boarding.

ACEP is committed to ensuring the highest standard of patient and physician safety, and we continue to be extremely concerned about the escalation of violence directed at health care workers, specifically those who work in the ED. Prior to the onset of the pandemic, violence in health care was already a concern, and it has only gotten worse. According to a 2022 ACEP survey, 85% of emergency physicians believe the rate of violence experienced in EDs has

increased over the past five years, and 89% of emergency physicians agree that ED violence harms patient care, including a result of increased wait times and a loss of staff productivity.

While emergency physicians are exposed to significant rates of verbal and physical abuse, reported rates likely do not represent the full impact of ED violence. There are many challenges in accurately tracking violent incidents, in no small part due to the fact that many health care workers decline to report incidents for fear of retaliation or feelings that reporting is not worth the time. ED violence creates additional stress and lowers morale, as a patient who assaults a health care worker in the ED must still be evaluated—and they are often treated by either by the physician or nurse they just assaulted or by one of their colleagues. Even in cases where law enforcement does make an arrest for violent behavior, the charges are often not pursued by district attorneys and offenders are not prosecuted. Violence in the ED is also subject to unique considerations, such as federal laws governing patient privacy protections and requiring stabilization of patients with emergency medical conditions—meaning that so many of these incidents go completely unseen by the public.

Violence against emergency physicians and other ED staff must not be accepted as "just part of the job." Physical violence, intimidation, and threats are not accepted in any other workplace, and they should not be allowed or tolerated in a health care setting. ***We ask that CMS and the entire Biden Administration enact policies to help stem the tide and protect those who provide the health care safety net.***

Solicitation of Comments on Behavioral Health and Suicide Prevention in the Hospital OQR Program

CMS seeks broad input on behavioral health as a measurement topic area in the Hospital OQR Program based on, but not limited to, the following matters: (1) priorities for measuring outcomes of outpatient behavioral health services, particularly by setting within the hospital outpatient department; and (2) quality measure approaches to improve behavioral health access in outpatient settings.

This is a critical time for improving the mental health care that is provided in our country. As you well know, our nation's mental health and substance use disorder (SUD) crises have been exacerbated by the myriad impacts of COVID-19. An estimated more than 100,000 Americans died due to overdose from July 2021 to July 2022, with what some have noted as an "epidemic within a pandemic."[10] EDs throughout the country have also witnessed a sharp increase in mental health-related visits, particularly among children and young adults—in part due to the continued lack of access to desperately needed acute and long-term mental health care services. Pediatric ED visits related to mental health increased by 24 percent increase for children 5-11 years of age and 31 percent for children 12-17.[11]

ACEP believes that there is a need and an opportunity to enhance behavioral health and suicide risk screening, and the ED setting could be utilized to expand implementation of these interventions. Research has suggested that

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[10] Department of Health and Human Services. (2023). SAMHSA Announces National Survey on Drug Use and Health (NSDUH) Results Detailing Mental Illness and Substance Use Levels in 2021. Retrieved from https://www.hhs.gov/about/news/2023/01/04/samhsa-announces-national-survey-drug-use-health-results-detailing-mental-illness-substance-use-levels-2021.html.
[11] Radhakrishnan L, Leeb R, et. al. (2022). Pediatric Emergency Department Visits Associated with Mental Health Conditions Before and During the COVID-19 Pandemic — United States, January 2019–January 2022. MMWR Morb Mortal Wkly Rep 2022; 71(8);319-324. https://www.cdc.gov/mmwr/volumes/71/wr/mm7108e2.htm.

universal suicide risk screening of adult ED patients approximately doubles the number (from 3% to 6%) of patients identified as needing care for acute/emergent suicide risk.[12] Findings from universal ED screening programs suggest that the patients identified because of universal screening are genuine cases, in the sense of having similar risk factors, and similar downstream rates of suicide attempt and death, as the patients identified via current usual care. And, under current usual care, those rates are very high. For example, Californians with ED visits involving intentionally self-inflicted injury were approximately 56 times more likely than demographically similar Californians overall to die by suicide in the next year. In addition, Californians with ED visits involving suicidal ideation were approximately 31 times more likely to die by suicide in the subsequent year.[13] Therefore, we believe that expanded suicide risk screening in the ED is clinically appropriate.

However, although the benefit of screenings is clear, major barriers exist in practical application of these screenings in the ED. Currently, there is not an established infrastructure or payment mechanism to ensure that these screenings are conducted consistently. With respect to payments, there is no way to be appropriately reimbursed for Safety Planning Intervention (SPI), the best clinical practice and standard of care for ED patients identified with suicide risk. Specifically, there is no Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) code that may be reported separately from other services furnished during an ED visit and for which the staffing and other elements align with effective and efficient furnishing of SPI. Therefore, enabling effective and efficient implementation of SPI for ED patients when indicated will likely require a new designated payment mechanism.

In addition, as previously mentioned, boarding has reached crisis levels in EDs across the country, due in part to the shortage of psychiatric beds. Suicide risk screening could compound the current boarding problem should these screenings lead directly to inpatient hospitalization. Therefore, addressing the issue of boarding is even more essential if the goal is to increase suicide risk screenings. Further, the coordination of care across the health care continuum is imperative to improve in conjunction to any effort for universal suicide risk screening in the ED. Innovative alternative models to improve emergency psychiatric care and reduce psychiatric patient boarding must be integrated into more communities across the country to alleviate burden, especially on rural and under-resourced communities.

Solicitation of Comments on Telehealth as a Measurement Topic Area in the Hospital OQR Program

CMS is considering adding a measure focused on telehealth quality and seeks comment on the following topics: (1) inclusion and prioritization of areas of telehealth-related care; (2) addressing quality gaps in outpatient telehealth-related care; (3) capturing utilization, and disparities resulting from utilization, of telehealth-related care for outpatient settings and services; and (4) understanding patient experience with outpatient telehealth services.

For years, ACEP has strongly supported the delivery of telehealth services by board-certified emergency physicians, especially to expand access to care in rural areas. Telehealth programs can expand patient access to an emergency physician in inner city or rural ED settings that would not normally be able to economically support that level of

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[12] Miller IW, Camargo CA Jr, Arias SA, et al. Suicide Prevention in an Emergency Department Population: The ED-SAFE Study. JAMA Psychiatry. 2017;74(6):563-570. doi:10.1001/jamapsychiatry.2017.0678

[13] Goldman-Mellor S, Olfson M, Lidon-Moyano C, Schoenbaum M. Association of Suicide and Other Mortality With Emergency Department Presentation. *JAMA Netw Open*. 2019;2(12):e1917571. Published 2019 Dec 2. doi:10.1001/jamanetworkopen.2019.17571

provider. We believe that telehealth services – if used appropriately – may support or expedite the delivery of emergency care.

Should CMS add a telehealth measure to the Hospital OQR program, it is imperative to be cognizant of the health equity impacts of telehealth and the disparities that will persist even with the increased usage of telehealth. While there is significant potential to help improve access to care for vulnerable populations using digital technologies, unfortunately, in the short-term, telehealth may not be an effective tool by itself to reduce health care disparities.

There are many structural barriers in place—particularly the lack of access to broadband in lower-income and rural communities and the disparities in smartphone and compatible device ownership—that should be addressed when discussing advancement in telehealth. According to a Pew Research Center survey, while 79 percent of suburban households and 77 percent of urban households reported having broadband internet connection, only 72 percent of rural households reported having broadband internet connection. This disparity is even more pervasive in terms of race and ethnicity – while 80 percent of white adults report having broadband internet at home, only 71 percent of Black adults and 65 percent of Hispanic adults say they have broadband internet at home. Further, 89 percent of suburban and 84 percent of urban American adults own smartphones, whereas only 80 percent of survey respondents in rural areas reported the same.[14] Americans over the age of 65 are approximately 24 percent less likely than the general population to own a smartphone.[15] As decreased access to technological devices correlates with lower "tech readiness," vulnerable populations who experience inequities in access to technology may also experience difficulties in access to, comprehension of, and proper usage of telehealth innovations. All in all, we must grapple with and attempt to correct the unfortunate reality that those in most significant need of these services are the ones who have the most trouble accessing them.

ACEP therefore supports efforts, such as the Federal Communication Commission's (FCC's) Connected Care Pilot Program, that cover the costs of broadband connectivity, network equipment, and information services necessary to provide telehealth and other remote care services to patients in rural and underserved communities, as well as other efforts to reduce and eliminate existing gaps in access for other vulnerable or in-need populations.

Proposed Requirements for the Rural Emergency Hospital Quality Reporting (REHQR) Program

CMS establishes policies for retaining, adding, modifying, and removing measures from the REHQR program based on the processes used in the Hospital OQR and ASCQR Programs. Further, CMS seeks comment on the use of electronic clinical quality measures (eCQMs) and care coordination measures including telehealth measures in the REHQR program going forward. CMS also seeks public comment on the implementation of a tiered quality measure approach in the REHQR Program, considerations in designing the structure of a tiered framework, the number of measures in each tier, and considerations for designating measures for tiers of such a framework. Finally, CMS proposes to make measure scores for claims-based measures proposed for the REHQR Program measure set publicly available beginning with measure data submitted for services provided in CY 2024. CMS establishes processes, deadlines, and exceptions for REHs with respect to reporting data that would be publicly reported.

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[14] https://www.pewresearch.org/fact-tank/2021/08/19/some-digital-divides-persist-between-rural-urban-and-suburban-america/
[15] https://www.pewresearch.org/internet/2017/05/17/technology-use-among-seniors/

ACEP strongly believes that there is a need to improve the quality of care delivered in rural areas. Research suggests that patients being treated in rural EDs may overall have less acute conditions but experience worse outcomes when compared to patients receiving care in urban EDs.[16] Therefore, we are supportive of CMS' proposals to support REHs' efforts to collect data, report quality measures, and improve performance.

A potential barrier to quality reporting that REHs may encounter is accessing the data they need to improve their quality performance and availability of staff to analyze the data. While the landscape for the collection and analysis of ED performance measure data has become incredibly sophisticated, access to that data by frontline users is typically contingent on providing data to and paying fees for a subscription service. REHs may not have the capital to invest in a registry or other mechanism for receiving and analyzing data. Thus, CMS should consider contributing additional resources to REHs to specifically help them with their quality reporting and data analytic capabilities.

CMS is also proposing to add four quality measures to the program, all of which have been previously endorsed by a consensus-based entity for use in the OQR Program. The measures are:
- Abdomen Computed Tomography (CT) - Use of Contrast Material
- Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients
- Facility 7-Day Risk-Standardized Hospital Visit Rate After Outpatient Colonoscopy
- Risk-Standardized Hospital Visits Within 7 Days After Hospital Outpatient Surgery

CMS believes that these measures strike a balance between the costs associated with reporting data and the benefits of ensuring safety and quality of care through measurement and public reporting. ACEP agrees and is supportive of the inclusion of these measures. **We especially support the ED boarding measure—OP-18—as it will be important to track whether REHs have the capacity and staff necessary to appropriately treat their patients in a timely manner.**

Proposed Updates to Requirements for Hospitals to Make a Public List of Their Standard Charges

Proposals to Improve and Enhance Enforcement

CMS seeks comment on additions and modifications to its enforcement regulations, including requiring an authorized hospital official to certify the accuracy and completeness of hospital price transparency data, requiring hospitals to acknowledge receipt of warning notices, allowing CMS to notify a health system's leadership of noncompliance of one of its hospitals, and allowing CMS to publicize information related to CMS's assessment of a hospital's compliance, compliance actions taken against hospitals (including the status and outcome of those actions), and notifications sent to health system leadership.

ACEP appreciates CMS' willingness to improve price transparency and accountability for patients. However, we urge CMS to keep in mind issues that are unique to emergency medicine and to therefore NOT include ED care in the requirements related to standard charges and subsequent enforcement mechanisms. In the ED, minutes and seconds

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[16] Joynt KE, Harris Y, Orav EJ, Jha AK. Quality of care and patient outcomes in critical access rural hospitals. JAMA. 2011 Jul 6;306(1):45-52. doi: 10.1001/jama.2011.902. PMID: 21730240; PMCID: PMC3337777.

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 broad range of ultimate diagnoses and require a large variety of patient-specific lab tests, radiology exams, and other interventions.

As emergency physicians, we are bound by the Emergency Medical Treatment and Labor Act (EMTALA), which guarantees access to emergency medical care for everyone, regardless of insurance status or ability to pay. EMTALA stipulates that a hospital may not place any signs in the ED regarding prepayment of fees or payment of co-pays and deductibles since they 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 over three decades ago. If we attempt to get pricing information to patients prior to stabilizing them, not only would that constitute 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. *Therefore, we want CMS to be cognizant of the effect that sharing information about ED costs may have on a patient's willingness to seek medical attention if they believe they are experiencing a medical emergency.*

Request for Public Comments on Potential Payment under the IPPS and OPPS for Establishing and Maintaining Access to Essential Medicines

Shortages of critical medicines, including those used in the ED and emergency medical services (EMS) settings, have continued to increase. In order to address shortages of medications in hospitals, CMS is seeking comment on separate payment under the IPPS for establishing and maintaining access to a buffer stock of essential medicines. An adjustment under the OPPS could be considered for future years. Based on the public comments, CMS could decide to adopt a policy that would be effective for cost reporting periods beginning on or after January 1, 2024.

ACEP supports the intent of this proposal to mitigate the medication shortages we are experiencing across the country. However, we are concerned about the potential unintended consequences of implementing such a policy. As proposed, hospitals would be reimbursed for the costs associated with establishing and maintaining a 90-day stockpile of essential medications as defined by the Administration for Strategic Preparedness and Response (ASPR). This policy could incentivize hospitals to stockpile these medicines, thereby potentially exacerbating shortages for hospitals that are unable to obtain medications quickly enough. In other words, hospitals would have to compete with one another for inventory, further creating silos and fragmentation in our nation's emergency preparedness infrastructure. As we learned from the COVID-19 pandemic, we need a cohesive national preparedness strategy, not one that may create further fragmentation. In addition, if the policy were to go into effect immediately

on January 1, 2024, hospitals across the country would rush to try to order all the essential medicines, creating national shortages of these medicines nearly overnight. Finally, the policy would also be expensive for smaller hospitals to comply with, as it does not cover the costs associated with acquiring the initial 90-day supply of the medications (only the costs of maintaining a stockpile).

As an alternative to this policy, CMS should consider paying a higher reimbursement fee to hospitals who are able to obtain domestically manufactured essential medications. Such a policy would enable hospitals to support domestic manufacturing and supply chain resiliency while also helping to avert drug shortages by investing in locally made, high-quality products.

We appreciate the opportunity to comment on this proposed rule. If you have any questions, please contact Erin Grossmann, ACEP's Manager of Regulatory and External Affairs, at egrossmann@acep.org.

Sincerely,

Christopher S. Kang, MD, FACEP
ACEP President