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August 1, 2024

The Honorable Diana DeGette
U.S. House of Representatives
2111 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Larry Buchson
U.S. House of Representatives
2313 Rayburn House Office Building
Washington, D.C. 20515

Dear Representatives DeGette and Buchson,

The American Academy of Emergency Medicine (AAEM) is the specialty society of board-certified emergency physicians. We are committed to the principle of fair and equitable practice environments to allow emergency physicians to provide the highest quality of patient care. Founded in 1993, AAEM represents over 8,000 emergency physicians and medical students across the United States.

Our letter responds to your request for information (RFI) on the 21st Century Cures Act (The Act) and specifically addresses the information blocking provision of The Act, which passed in 2016. The RFI asks what additional reforms, support mechanisms, or incentives are needed to enhance or improve the effectiveness of the steps already taken, including any structural reform to agencies, offices, or programs involved.

The Act established two primary areas of prohibited information blocking. First, the Cures Act defines information blocking as a practice that is likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information. It also specifies that for a health care provider to be deemed to have engaged in information blocking, such provider must know that a practice is unreasonable and is likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information. Second, the Cures Act authorizes the Office of the Inspector General (OIG) to investigate information blocking claims. Physicians (and others) whom the OIG determines to have committed information blocking are subject to disincentives that are spelled out in rulemaking.

Regulations have provided the scope of OIG information blocking authority.

- In 2020, the Department of Health and Human Services (HHS) Office of the National Coordinator for Health Information Technology (ONC) created eight exceptions that do not constitute information blocking. These eight exceptions are divided into two categories: 1) exceptions that involve not fulfilling requests to access, exchange, or use electronic health information (EHI); and 2) exceptions that involve procedures for fulfilling requests to access, exchange, or use EHI. The Emergency Department (ED) is not included under these exceptions.

- In 2024, HHS and ONC proposed specific disincentives for physicians, among others, participating in the Merit-based Incentive Payment System (MIPS) who commit information blocking. According to the ONC, "Under the Promoting Interoperability performance category of the Merit-based Incentive Payment System (MIPS), a MIPS eligible clinician that commits information blocking will not be a meaningful user of certified electronic health record (EHR) technology

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> in a performance period and will therefore receive a zero score in the Promoting Interoperability performance category of MIPS, if required to report on that category. Similarly, if a MIPS eligible clinician participating in group reporting is found to have committed information blocking, only the individual will be subject to a disincentive, not the group. The Promoting Interoperability performance category score typically can be a quarter of a clinician or group's total MIPS score in a year."

The AAEM supports patient access to medical records and understands the need to reduce information blocking. However, the ED is a unique setting and the AAEM believes the best practice in the ED involves direct communication and discussion of tests results between the ED physician and team and the patient and/or their representative before EHI is available. Under the existing regulations, multiple scenarios could occur without a critical physician-patient/family discussion. First, when patients or families view tests results in the waiting area, the patient may leave the emergency department (left without being seen or LWBS) despite having an issue that needs to be addressed for optimal care. Second, patients may learn complicated and/or devastating information while alone in a room (e.g., a new diagnosis of malignancy, pregnancy loss, false assumption of serious issues, etc.).

The AAEM asks that the next iteration of the Cures Act and/or future regulations addresses the above issue and creates an emergency department exception or other process, potentially time limited up to 24 hours, under the Cures Act that allows ED physicians adequate time to discuss any test results with the patient or families after the disposition is assigned. AAEM would also support an updated regulation which addresses this issue either through their exceptions process or other authorities.

AAEM looks forward to working with you on this important issue.

Sincerely,

Robert A Frolichstein, MD FAAEM
President

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