American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

September 15, 2025 **CMS-1834-P**

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency

Dear Administrator Oz:

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On behalf of our nearly 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on the Calendar Year (CY) 2026 Medicare Outpatient Prospective Payment System (OPPS) Proposed Rule, as many of the proposed policies have a significant impact on our members and the patients we serve, especially with regards to the Emergency Care Access and Timeliness Electronic Clinical Quality Measure.

Payment for Partial Hospitalization and Intensive Outpatient Services (IOP)

An intensive outpatient program (IOP) is a distinct and organized program of psychiatric services for individuals who have an acute mental illness, which includes, but is not limited to, conditions such as depression, schizophrenia, and substance use disorder (SUD). In the CY 2024 OPPS final rule, CMS finalized payment for IOP services furnished in hospital outpatient departments (HOPDs), Community Mental Health Centers (CMHCs), Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Opioid Treatment Programs (OTPs). In addition, CMS established Medicare Part B coverage for IOP services provided by OTPs for the treatment of opioid use disorder (OUD). In this proposed rule, CMS proposes minor changes to IOP payment, but maintains the overall payment paradigm.

ACEP believes that freestanding SUD facilities and other entities that furnish IOP services serve an important function in their communities. Access to these services is critical in the management and treatment of SUD and may help prevent overdoses or other acute conditions that result in an emergency department (ED) visit. Because of their vital role in treatment engagement and the life-saving services they provide, freestanding SUD facilities should have a sustainable structure for reimbursement.

Services That Will Be Paid Only as Inpatient Services

The Inpatient Only (IPO) list was created to identify services for which Medicare will make payment only when furnished in the inpatient hospital setting because of the invasive nature of the procedures, the underlying physical condition of the Medicare patient, or the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged. In the CY 2021 OPPS final rule, CMS finalized a policy to eliminate the IPO list over a three-year transitional period. In the CY 2022 final rule, CMS halted this elimination after clinical review of the services removed from it in CY 2021 in the first phase of its elimination, and returned most removed services back to the IPO list.

In this proposed rule, CMS again proposes to remove the IPO list through a three-year transition, this time completing the elimination by January 1, 2029. Services that are removed from the IPO list would still be subject to the "two-midnight rule," wherein patients that spend less than two midnights in a hospital are treated as an outpatient, while patients that spend more than two midnights in a hospital are treated as an inpatient.

In general, ACEP has long expressed concerns about the two-midnight rule. The difference between having an "inpatient" and "outpatient" status on patients could potentially be significant, as beneficiaries generally face a 20 percent coinsurance for most outpatient services. Unfortunately, many beneficiaries do not know that they are actually outpatients. If they are in the hospital, they assume they are inpatients and subject to the inpatient Medicare rules. Hospitals are required to provide a Medicare Outpatient Observation Notice (MOON) to Medicare beneficiaries informing them that they are outpatients receiving observation services and are not inpatients. However, it is still confusing for beneficiaries, and removal of the IOP list will only add to this confusion. All in all, we believe that CMS must ensure that Medicare beneficiaries clearly understand their cost-sharing obligations if they receive one of these procedures being removed from the IPO list.

We do appreciate however that CMS is proposing to exempt procedures that have been removed from the IPO list from certain medical review activities to assess compliance with the two-midnight rule until CMS determines that the service or procedure is more commonly performed in the Medicare population in the outpatient setting. We believe that subjecting these procedures to medical review would add confusion and additional, unnecessary administrative burden to physicians—and urge CMS to finalize that proposal.

Proposed CY 2026 Non-Opioid Treatments for Pain Relief

CMS is proposing to continue policies to provide temporary additional payments for certain non-opioid treatments for pain relief in the hospital outpatient department (HOPD) and ASC settings from January 1, 2025 through December 31, 2027, consistent with statute. CMS is proposing five drugs and six devices to qualify as non-opioid treatments for pain relief, and CMS proposes these products be paid separately in both the HOPD and ASC settings starting in CY 2026. CMS is soliciting comment and supporting documentation from interested parties on additional products that may qualify for separate payment under this provision for CY 2026.

ACEP supports the concept of separately paying for the use of non-opioid alternatives for pain management under the OPPS and ASC payment system—and encourages CMS to expand the policy going forward to include coverage and payment for clinicians of non-opioid treatments in the emergency department (ED) setting. As emergency physicians, we are on the front lines of the opioid epidemic. In addition to addressing this crisis on the treatment side, emergency physicians are also taking steps to address this crisis on the

prevention side by implementing innovative alternative treatments to opioids (ALTO) programs. ALTO uses evidence-based protocols like nitrous oxide, nerve blocks, trigger point injections, and other non-opioid pain management tools to treat a patient's pain in the ED. Successful ALTO programs in New Jersey and Colorado have dramatically and quickly reduced opioid prescriptions in the ED. In New Jersey, the ALTO program at St. Joseph's Hospital saw opioid prescriptions drop by 82 percent over two years.[1] These results were recently replicated at 10 hospitals in Colorado, where hospital systems noted a 36 percent drop in opioid prescriptions in just the first six months of the program.[2]

In terms of payment, the additional cognitive work involved in implementing an ALTO program is not currently recognized or reimbursed in most settings, including the ED. The individual procedures may be reimbursed depending on the other services the patient receives, but many nerve blocks for example are bundled with the primary surgical procedure. Given the importance of using non-opioid treatments for pain as a means to help address the opioid crisis, we strongly recommend that CMS pay separately for both the facility and professional components of these critical treatments. We also urge CMS to consider introducing a payment model or grant funded by the Center for Medicare & Medicaid Innovation to help spread best practices for using non-opioids to treat pain.

Cross-Program Proposals for the Hospital Outpatient Quality Reporting (OQR), Rural Emergency Hospital Quality Reporting (REHQR), and Ambulatory Surgical Center Quality Reporting (ASCQR) Programs

Measure Concepts under Consideration for Future Years in the Hospital OQR, REHQR, and ASCQR Programs–Request for Information (RFI): Well-Being and Nutrition

CMS is seeking input on well-being and nutrition measures for consideration in future rulemaking for the Hospital OQR, REHQR, and ASCQR Programs. CMS defines well-being as "a comprehensive approach to disease prevention and health promotion, as it integrates mental and physical health while emphasizing preventative care to proactively address potential health issues," which "emphasizes person-centered care by promoting the well-being of patients and family members." The agency seeks comment on tools and measures that assess overall health, happiness, and satisfaction in life, which could include aspects of emotional well-being, social connections, purpose, and fulfillment, as well as tools and measures that assess optimal nutrition including strategies, guidelines, and practices that promote healthy eating habits and ensure individuals receive the necessary nutrients for maintaining health, growth, and overall well-being, all with a focus on preventive care.

ACEP agrees that preventive care, nutrition, and well-being can improve health outcomes. However, we want to make clear that quality measures cannot be developed within a short timeframe. In fact, CMS does not directly support or fund the development of new measures, but relies instead on outside entities including clinical data registries to develop and test new measures. However, the requirements placed on these clinical registries around developing measures lead to a time-consuming and expensive process that can significantly inhibit the development of new measures in priority areas—such as nutrition and well-being. Thus, we strongly recommend that CMS take a careful look at all the existing regulations impacting clinical data registries. In particular, 42 CFR § 414.1400 currently mandates slews of burdensome, unnecessary requirements that should be modified or eliminated. These requirements make the standard for clinical data registries to operate, develop,

[1] Wang HL. No joke: N.J. Hospital uses laughing gas to cut down on opioid use. NPR. April 2016.
[2] Stader D. Opioid Initiative Wave I: ALTO – The Colorado Experience.
https://www.acep.org/contentassets/7c78d4de4f174ecb966efb8fd58aab28/webinar_opioidsw1_5coloradoalto.pdf

and maintain measures far greater than that which CMS holds itself to when it comes to maintaining quality measures. Developing and fully testing a single new quality measure costs between $250,000 and $1 million. In order for measure development to be a more clinician-driven process that has clinicians who see patients every day leading the creation of more relevant evaluative measures that assess patients' nutrition, well-being, and overall health and happiness, CMS must alleviate some of these burdensome and cost-prohibitive requirements.

Emergency Care Access and Timeliness Electronic Clinical Quality Measure (eCQM)

Background

ACEP strongly supports CMS' proposals to incorporate the Emergency Care Access and Timeliness eCQM into CMS reporting programs going forward. The goal of the measure is to help monitor the issue of patients "boarding" in the ED—a scenario where patients often wait for hours, days, or even weeks in the ED while waiting for an inpatient bed after admission to the hospital or transfer to another facility. Boarding is overwhelming emergency physicians, non-physician clinicians, nurses, and other staff who are doing all they can to treat or stabilize every emergency patient that needs care. Our nation's safety net is on the verge of breaking beyond repair, and EDs are gridlocked. Boarding has become its own public health emergency, and **the system is stuck**.

Boarding is also a major national security and preparedness issue—with the system's ability to respond to a large-scale crisis significantly diminished since the frontline is already at a breaking point on any given "normal" day. The impact of a mass casualty event while our health care safety net is already strained beyond its limits may have serious, life-threatening consequences for millions of patients.

Any emergency patient can find themselves boarded, regardless of their condition, age, insurance coverage, income, or geographic area. Patients in need of intensive care may board for hours in ED beds not set up for the extra monitoring they need. Those in mental health crisis, often children or adolescents, can board for *months* in chaotic EDs while waiting for a psychiatric inpatient bed to open anywhere. Patients may delay or avoid emergency care and risk their physical and mental health because of these systemic bottlenecks.

ED boarding and crowding are not caused by ED operational issues or inefficiency and are entirely outside the control of the highly skilled emergency physicians, nurses, and other ED staff doing their best to provide equitable, high quality and safe care. Rather, they stem from broader health system dysfunction. This dysfunction also leads to negative patient outcomes, as a substantial body of evidence has shown that ED boarding and crowding lead to increased cases of mortality related to downstream delays of treatment for both high and low acuity patients.[3,4] Boarding also leads to ambulance diversion, increased adverse events, preventable medical errors, lower patient satisfaction, violent episodes in the ED, emergency physician and staff burnout, and higher overall health care costs.

Measurement is essential to identifying, diagnosing, and solving the complex boarding problem. Unfortunately, our ability to measure this problem has become limited, as CMS eliminated an important measure regarding ED overcrowding, wait times, and boarding by sunsetting sunset ED-2, the Admit Decision Time to ED

[3] Hsuan C, Segel JE, Hsia RY, Wang Y, Rogowski J. Association of emergency department crowding with inpatient outcomes. Health Serv Res. 2023 Aug;58(4):828-843. doi: 10.1111/1475-6773.14076. Epub 2022 Oct 12. PMID: 36156243; PMCID: PMC10315392

[4] do Nascimento Rocha HM, da Costa Farre AGM, de Santana Filho VJ. Adverse Events in Emergency Department Boarding: A Systematic Review. J Nurs Scholarsh. 2021 Jul;53(4):458-467. doi: 10.1111/jnu.12653. Epub 2021 Mar 31. PMID: 33792131.

Departure Time for Admitted Patients measure, in the Fiscal Year (FY) 2022 Inpatient Prospective Payment System (IPPS) final rule. ACEP strongly opposed the removal of this measure as it was not only a specific measure capturing ED boarding, but also one of the only measures available to track this statistic and provide incentives and enforcement for hospitals to address systemic issues to help reduce wait times and boarding.

In the CY 2024 OPPS/ASC proposed rule, CMS again proposed to eliminate another boarding and crowding-related measure, the Left Without Being Seen (LWBS) Measure, stating it was doing so due to indications that (1) limited evidence linked 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. ACEP strongly opposed the removal of this measure as well, and we were pleased that CMS reversed its position in the final OPPS rule and ultimately retained the measure.

We were very pleased earlier this year when during the pre-rulemaking measure review process, the Partnership for Quality Measurement committee voted to recommend inclusion of a new boarding measure, the Emergency Care Capacity and Quality eCQM, which we strongly supported during its development. This measure, whose name has since been changed to the Emergency Care Access and Timeliness eCQM, is essential to tracking the ongoing issue of ED boarding. Thus, we thank CMS for proposing to integrate the measure into CMS's quality reporting programs.

We have some specific comments below about the proposed measure specifications and the timeline for adopting the measure.

Measure Overview

Outcomes

The measure is specified for the hospital setting and calculates the proportion of four outcome metrics that quantify access to and timeliness of care in an ED setting against specified thresholds, including:

1. The patient waited longer than 1 hour after arrival to the ED to be placed in a treatment room or dedicated treatment area that allows for audiovisual privacy during history-taking and physical examination; or
2. The patient left the ED without being evaluated; or
3. The patient boarded in the ED for longer than 4 hours; or
4. The patient had an ED length of stay (LOS) of longer than 8 hours.

An encounter is considered part of the numerator if it includes any one of the four numerator events, with events not being mutually exclusive and each contributing only once to the numerator. ED encounters with ED observation stays are excluded from components (3) and (4) but are included in the denominator. Patients who have a "decision to admit" after an ED observation stay remain excluded from criteria (3) calculations.

We appreciate that CMS accepted our recommendations and those from The Joint Commission for developing thresholds. Particularly, we support the 4-hour maximum timeframe that all admitted patients should remain in the ED between admission order and patient departure referred to in this outcome. We emphasize that this 4-hour threshold should not be treated as a mean or median target, but rather as an absolute maximum limit. Total time in the ED should never exceed 8 hours. We also feel strongly that future performance targets should move towards shorter time periods as the quality gap closes; for example, a target of 6 hours of total time in

the ED and a target of 2 hours from decision/intent to admit to departure. For patients who are admitted to intensive care units (ICUs) and older adults aged 65 and older, who are disproportionately adversely affected by ED boarding,[5][6] boarding times should be kept as short as possible for these high-risk groups.

Calculation and Standardization

The measure score is first calculated at the individual ED level as the proportion of ED encounters where any one of the four outcomes occurred. Raw measure scores are then standardized by ED case volume using z-scores. The z-score, or standard score, indicates how many standard deviations a data point is from the mean of a normal distribution. It is calculated by subtracting the mean from a data point, then dividing the result by the standard deviation. For the Emergency Care Access & Timeliness eCQM, a volume-adjusted z-score shows how an ED's performance compares to the average for similar-volume EDs, addressing differences in patient population in HOPDs and ensuring fair "like to like" comparisons between EDs of similar size. ED volume strata are defined in volume bands of 20,000 ED visits, and each ED is assigned to only one volume stratum.

The measure is currently formatted as an intermediate outcome measure; a patient encounter that meets one of the outcomes is weighted the same as a patient encounter that meets multiple outcomes. Therefore, from a quality assessment standpoint, it is extremely difficult to discern which of the four outcomes needs the most improvement and impossible to identify any correlations between outcomes. Structuring the measure as a composite measure instead would allow for more granular analysis of specific deficiencies rather than capturing the universe of deficiency as a whole and may allow for analysis of patterns in overlapping negative ED encounter outcomes. ACEP recognizes that all four outcomes proposed reflect quality gaps in patient experience in the ED. However, we feel that boarding is the number one priority that needs to be measured and rectified. Thus, if the eCQM is structured as a composite measure, Outcome 3 should be weighted more heavily than Outcomes 1, 2, and 4 (40% to 20%). While Outcomes 1 and 2 are influenced by boarding, they may also be influenced by other factors (such as ED staffing) that are related to, but not always, downstream effects of boarding.

Stratification

The results of the Emergency Care Access & Timeliness eCQM are stratified into four groups, two by age (18 years and older, and under 18 years) and two by mental health diagnoses (with, and without). According to CMS, the stratification of results by age and mental health diagnosis, as well as standardization of measure performance scores by volume, is sufficient to account for differences between hospitals without further need for risk adjustment.

While we agree with this approach for Outcomes 1, 2, and 4, "like to like" comparison is not appropriate for Outcome 3. All hospitals, regardless of ED volume, have an equal opportunity and responsibility to manage the hospital so that boarding times are kept at a minimum. Therefore, while we acknowledge Outcome 3 may vary by hospital size, we recommend reporting without standardization by volume.

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[5] Mohr NM, Wessman BT, Bassin B, Elie-Turenne MC, Ellender T, Emlet LL, Ginsberg Z, Gunnerson K, Jones KM, Kram B, Marcolini E, Rudy S. Boarding of Critically Ill Patients in the Emergency Department. Crit Care Med. 2020 Aug;48(8):1180-1187. doi: 10.1097/CCM.0000000000004385. PMID: 32697489; PMCID: PMC7365671

[6] Roussel M, Teissandier D, Yordanov Y, Balen F, Noizet M, Tazarourte K, Bloom B, Catoire P, Berard L, Cachanado M, Simon T, Laribi S, Freund Y; FHU IMPEC-IRU SFMU Collaborators; FHU IMPEC−IRU SFMU Collaborators. Overnight Stay in the Emergency Department and Mortality in Older Patients. JAMA Intern Med. 2023 Dec 1;183(12):1378-1385. doi: 10.1001/jamainternmed.2023.5961. PMID: 37930696; PMCID: PMC10628833.

Timeline for Measure Adoption

Hospital Outpatient Quality Reporting (OQR) Program

CMS proposes to adopt the eCQM into the Hospital OQR Program beginning with voluntary reporting for the CY 2027 reporting period followed by mandatory reporting beginning with the CY 2028 reporting period/CY 2030 payment determination in the Hospital OQR Program. CMS' rationale is that this would provide hospitals sufficient time to test and integrate the eCQM into existing clinical workflows, and that limiting voluntary reporting to 1 year prioritizes addressing long ED wait times and ED boarding. In conjunction with the proposed inclusion of this measure, CMS proposes to remove The Median Time for Discharged ED Patients measure and the Left Without Being Seen measure, essentially replacing these two measures with the Emergency Care Access and Timeliness measure.

ACEP supports this transition to the new measure and urges CMS to finalize the timeline as proposed.

Rural Emergency Hospital Quality Reporting (REHQR) Program

CMS proposes to incorporate the Emergency Care Access & Timeliness eCQM in the REHQR Program for reporting beginning with the CY 2027 reporting period/CY 2029 payment determination. Due to concerns with the measure's applicability to rural emergency hospitals (REHs) as vocalized during the pre-rulemaking measure review process, CMS is proposing optional reporting of this measure for REHs. REHs would choose to report either the Median Time for Discharged ED Patients measure or the Emergency Care Access & Timeliness measure to "provide greater flexibility for REHs to implement EHR infrastructure that meets their individual needs while still prioritizing measurement of the variation in access to and the timeliness of emergency care, the goal of promoting interoperability, and reducing burden for REHs in the long term."

ACEP supports CMS's proposal to make this measure optional in the REHQR Program. Facilities designated as REHs have 50 or fewer beds, are required to provide 24-hour emergency and observation services, and can elect to furnish other outpatient services. An REH cannot have inpatient beds, except those furnished in a distinct part unit licensed as a skilled nursing facility. Despite ACEP's prior recommendations, a physician with experience in emergency medicine (either a board-certified emergency physician or a family physician with significant expertise in emergency medicine) is not required to provide the care or oversee the care delivered by non-physician practitioners in an REH; rather, a doctor of medicine (MD) or doctor of osteopathy (DO), a physician assistant, a nurse practitioner, or a clinical nurse specialist with training or expertise in emergency care must always be onsite or on-call and available onsite within 30 minutes, or within 60 minutes if certain frontier or remote area criteria are met.

As such, REHs have constraints that may skew data or have external factors that contribute to extended wait times or boarding outside of the REH's control. For example, as previously mentioned, rural hospitals often experience difficulty finding destination hospitals to accept patients with needs that extend beyond the capabilities of their rural hospital. Thus, the receiving facility should be evaluated for the time from patient admission to patient transfer, rather than the facility that lacks the capabilities necessary to treat the patient.

Updates to Requirements for Hospitals to Make Public A List of their Standard Charges

CMS is proposing several modifications to the Hospital Price Transparency (HPT) regulations to ensure that hospitals provide meaningful, accurate information about the amount they charge for health care items and services. CMS proposes to require hospitals disclose the tenth, median and ninetieth percentile allowed amounts in machine-readable files (MRFs) when payer-specific negotiated charges are based on percentages or algorithms as well as the count of allowed amounts used to determine these percentiles, to more accurately reflect the distribution of actual prices that the hospital has received for an item or service. CMS also proposes to require hospitals to attest that they have included all applicable payer-specific negotiated charges in dollars that can be expressed as a dollar amount, and for payer-specific negotiated charges that are not knowable in advance or cannot be expressed as a dollar amount, the hospital has provided in the MRF all necessary information available to the hospital for the public to be able to derive the dollar amount. Lastly, CMS proposes to reduce the amount of civil monetary penalty for a noncompliance with the HPT requirements by 35 percent when a hospital agrees with CMS' determination of their noncompliance and waives the right to a hearing by an Administrative Law Judge.

ACEP supports the Trump Administration's commitment to improving price transparency. As the administration continues to refine requirements around price transparency, we urge the administration to keep in mind the unique factors of emergency medicine that make it difficult to estimate prices for emergency services. We strongly believe that a patient's concern should be focused on receiving the appropriate care, rather than choosing their emergency care based solely on cost. In the ED, minutes and seconds matter and emergency physicians are often required to exercise their best clinical judgment quickly. Patients who have life-threatening illnesses and injuries obviously do not have the ability to shop around for a provider. Furthermore, in delivering acute care, knowing what patients' total out-of-pocket costs will be before they are even 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 large range of ultimate diagnoses and require a large variety of patient-specific lab tests, radiology exams, and other interventions. This is very different from being able to figure out total costs for a patient with a small, clean, superficial laceration or a sore throat. Thus, the complicated and unpredictable nature of emergency care makes it extremely difficult to estimate ahead of time what costs are going to be for an individual patient encounter.

As emergency physicians, we are subject to the Emergency Medical Treatment and Labor Act (EMTALA), which guarantees that we provide patients with emergency medical care regardless of their insurance status or ability to pay. ACEP strongly supports the patient protections embedded within the EMTALA requirements. EMTALA stipulates that a hospital may not place any signs in the emergency department regarding the prepayment of fees or payment of co-pays and deductibles which 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 three decades ago. If we attempt to get pricing information to patients prior to stabilizing them, not only would that be 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. While the penalties for violating EMTALA are steep, our bigger concern is that if transparency for emergency care is not

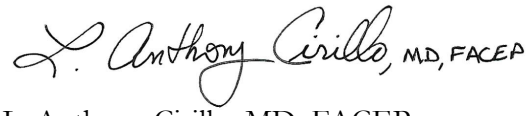
approached carefully, we could inadvertently be putting our patients in a position of making life-or-death health care decisions based on costs.

It is also important to note that people who think they are having an emergency have every right to go to the ED without worrying about whether the services they receive will be covered by their insurance. A provision in federal law called the "Prudent Layperson Standard" (PLP) states that payers must cover any medical condition, "manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1) placing the health of the individual (or a pregnant woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions, or 3) serious dysfunction of any bodily organ or part." First established under the Balanced Budget Act of 1997, the PLP originally applied to all of Medicare and to Medicaid managed care plans, and then was extended under the ACA to all insurance plans regulated under the Employee Retirement Income Security Act of 1974 (ERISA) and to qualified health plans in the state Exchanges.

Thus, given the critical laws that are in place that are meant to protect patients, as well as the difficulty in predicting prices for medical emergencies, we continue to believe that emergency care should not be subject to some of the price transparency requirements.

We appreciate the opportunity to provide comments. If you have any questions, please contact Laura Wooster, ACEP's Associate Executive Director of Advocacy and Practice Affairs at lwooster@acep.org.

Sincerely,



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