American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

August 18, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8016
Baltimore, MD 21244-8016

CMS-3419-P

Re: Medicare and Medicaid Programs; Conditions of Participation (CoPs) for Rural Emergency Hospitals (REH) and Critical Access Hospital CoP Updates

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 proposed rule, "Medicare and Medicaid Programs; Conditions of Participation (CoPs) for Rural Emergency Hospitals (REH) and Critical Access Hospital CoP Updates."

In the rule, CMS proposes conditions of participation (CoPs) for a new facility type under Medicare called rural emergency hospitals (REHs), created through the passage of the Consolidated Appropriations Act at the end of 2020. ACEP has long advocated for this concept, as we believe that REHs have the potential of improving access to quality emergency care in certain rural areas, especially those that have been impacted by recent hospital closures. CMS issued a request for information (RFI) last year as part of the CY 2022 Outpatient Prospective Payment System Proposed Rule for input on a broad range of issues affecting the establishment of this new facility type, and ACEP submitted a robust response. In those comments, we specifically emphasized the need for all services delivered in REHs to be supervised by emergency physicians either in-person or virtually via telehealth. **We are pleased that in this rule, CMS recognizes the value of having board-certified emergency physicians serve as medical directors but understand the rationale for why CMS did not propose to make that a requirement. While we still prefer that all services delivered in REHs be overseen by board-certified emergency physicians, we acknowledge that this is not always possible due to existing workforce challenges in rural areas. In cases where a board-certified emergency physician is not available, CMS should require that a physician with training and/or experience in emergency medicine (such as a family physician) provide the care or oversee the care delivered by non-physician practitioners. The level of training and education of physicians far exceeds that of non-physician practitioners—and emergency patients represent some of the most complex and critically ill patients in medicine.**

With that context in mind, we offer the following comments on the proposed CoPs.

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Proposed Basic Definitions and Requirements

In the proposed rule, CMS proposes the following definitions for REHs and CoPs.

- CMS defines an REH as "an entity that operates for the purpose of providing emergency department services, observation care, and other outpatient medical and health services in which the annual per patient average length of stay does not exceed 24 hours. The REH must not provide inpatient services, except those furnished in a unit that is a distinct part licensed as a skilled nursing facility to furnish post-REH or posthospital extended care services."
- CMS proposes to certify a facility as an REH if the facility was, as of December 27, 2020, a critical access hospital (CAH) or a hospital with no more than 50 beds located in a rural county.
- REHs must be in compliance with applicable Federal, state, and local laws and regulation. REHs also must be licensed in the state as an REH or be approved as meeting standards for licensing by the agency in the state or locality responsible for licensing hospitals.

ACEP supports these proposals. With respect to the requirement that the annual per patient average length of stay for REHs does not exceed 24 hours, we appreciate the flexibility CMS provides in recognizing that some patients may need to stay longer than 24 hours. There could be situations where a patient needs further medical attention, but it is not feasible to transfer the patient to a level I or level II trauma center within that 24-hour timeframe. In all, providing that flexibility allows REHs to safely discharge or transfer patients without being fearful of an arbitrary time period to do so.

Proposed Condition of Participation: Governing Body and Organizational Structure

Overall Governing Body Requirements

CMS is proposing that REHs must have an effective governing body, or responsible individual or individuals, that is legally responsible for the conduct of the REH. This governing body will have the responsibility, in accordance with state law, to determine which categories of practitioners are eligible candidates for appointment to the medical staff. ACEP supports these proposals, but as stated below, we believe that a physician with experience in emergency medicine should be included in the governing body and should serve as the medical director of the REH.

Telemedicine Credentialing and Privileging

CMS recognizes the "important role that telemedicine can play in the provision of care in rural communities" and is proposing a more flexible telemedicine and privileging process. Specifically, CMS is proposing requirements similar to the telemedicine credentialing and privileging process requirements established for hospitals and CAHs that would allow for an "optional and more streamlined credentialing and privileging process that REHs may use for physicians and practitioners providing telemedicine services for their patients." Under this alternative approach, the governing body of the REH whose patients are receiving the telemedicine services could grant privileges to distant-site physicians and practitioners based on the recommendations of its medical staff.

Overall, ACEP supports these proposals, as we appreciate CMS' efforts to reduce regulatory and administrative barriers to telehealth. ACEP believes that telehealth can serve as a method for physicians to deliver services or oversee

care provided by non-physician practitioners in REHs when in-person care and/or supervision is not possible. However, we caution CMS to ensure that the staffing standards of the distant-site telemedicine entity are equivalent to that of the REH—including a board-certified emergency physician or other physician with significant training and/or experience in emergency medicine.

ACEP seeks clarification as to whether the distant-site hospital and physicians and practitioners that are credentialed and privileged to provide telemedicine services within that hospital must be enrolled in Medicare. Although CMS first states that the REH must ensure that "the distant-site hospital providing the telemedicine services is a Medicare-participating hospital," CMS later concludes "that it is important that the medical staff of a distant-site telemedicine entity, ***which may not be a Medicare-participating hospital***, be included in an optional and streamlined credentialing and privileging process for those REHs electing to enter into agreements for telemedicine services with such entities" (emphasis added). **CMS must clarify that all distant-site hospitals, as well as the physicians and practitioners providing services in that distant-site hospital (even if they are contractors), must be enrolled in Medicare and appropriately qualified to provide services to Medicare beneficiaries. CMS should also clearly articulate the existing Medicare regulations regarding the supervision of non-physician practitioners and how telehealth can be a platform by which physicians can supervise care being delivered by non-physician practitioners.**

Proposed Condition of Participation: Emergency Services

CMS is proposing that REHs must comply with both the CAH and Hospital CoPs for emergency services, including a requirement that they have emergency services that meet the needs of their respective patients presenting at the individual facility; there be emergency services that are organized under the direction of a qualified member of the medical staff and are integrated with other departments of the REH; and adequate medical and nursing personnel qualified in emergency care to meet the needs of the facility. ACEP agrees with CMS in requiring REHs to comply with CAH and Hospital CoPs for emergency services; however, video laryngoscopes for endotracheal intubation, various trays for venous and arterial vascular access and chest tube placement, and an emergency ultrasound machine should be added as part of a CoP for REHs and rural emergency departments (EDs). Data obtained from various limited surveys of stakeholder organizations affiliated with ACEP reveal that most rural hospitals are already well equipped with all of this necessary, state-of-the-art equipment.[1] This additional equipment should be part of the emergency services CoP for REHs.

CMS is also seeking comment on the proposed staffing requirements for the provision of emergency services in an REH to gain insight on the appropriateness of not requiring a practitioner to be on-site at the REH at all times. **ACEP continues to believe that, when possible, board-certified emergency physicians should oversee all care delivered in REHs. There is no residency training program that prepares physicians to provide services in both urban and rural EDs as well as emergency medicine residency programs. However, when a board-certified emergency physician is not available, it is still critical that physicians experienced and/or trained in emergency medicine (such as family physicians) oversee care being delivered by non-physician practitioners in REHs.** Emergency patients represent some of the most complex and critically ill patients in

[1] "ACEP Rural Emergency Care Task Force 2020 Report to the ACEP Board of Directors," October 2020, available at: https://www.acep.org/rural/rural-newsroom/rural-news-articles/january-2021/rural-task-force-summary/.

medicine, and effective management of these patients requires years of specialized training. However, the training programs for physician assistants (PAs), clinical nurse specialists (CNSs), and nurse practitioners (NPs) are extremely abbreviated compared to medical training for physicians, and there is an even greater level of training required for these providers to meet a level of care that is safe for patients. The table below compares the training requirements between NPs, PAs, and physicians.

Comparison of Training Requirements			
	Physicians	**Nurse Practitioners**	**Physician Assistants**
Clinical education	4 years	2-3 years	2 years
Residency training	3 – 7 years	--None--	--None--
Clinical care training (including during medical school for physicians)	10,000-16,000 hours	500-720 hours	2,000 hours
Examinations	21 hours, 820 questions: - USMLE I: 8 hours, 280 questions - USMLE II: 9 hours, 315 questions - Specialty board: 4 hours, 225 questions	3 hours, 150-200 questions	5 hours, 300 questions

A standard of training for all practitioners delivering services in REHs also needs to be established. Rural emergency patients are not currently afforded the same level of assurance of adequate training of medical providers as emergency patients who present to urban EDs. This is not equitable for the rural community that is often more elderly with complex medical needs. All emergency patients deserve access to a physician and, preferably, a specialist in emergency medicine.

Proposed Condition of Participation: Laboratory Services

CMS is proposing that REHs must provide basic laboratory services that are essential to the immediate diagnosis and treatment of the patient. REHs should provide laboratory services that are consistent with nationally recognized standards of care for emergency services. In addition to the laboratory services identified in the CAH CoPs, CMS encourages REHs to provide laboratory services that include a complete blood count, basic metabolic panel (also known as a "chem 7"), magnesium, phosphorus, liver function tests, amylase, lipase, cardiopulmonary tests (troponin, brain natriuretic peptide, and d-dimer), lactate, coagulation studies (prothrombin time, partial thromboplastin time, and international normalized ratio), arterial blood gas, venous blood gas, quantitative human chorionic gonadotropin, and urine toxicology. Additionally, REHs must have emergency laboratory services that would be essential to the immediate diagnosis of the patient available 24 hours a day.

ACEP supports these proposals. However, we believe that blood, urine, Cerebrospinal fluid (CSF), and other body fluid cultures; CSF analysis and synovial fluid analysis; serum and urine pregnancy tests; and ammonia level tests should also be included in required laboratory services.

Proposed Condition of Participation: Radiologic Services

The proposed REH radiologic requirements mirror the radiologic requirements for CAHs:

- The services must be furnished by personnel qualified under state law and must not expose patients or staff to radiation hazards.
- The REH must provide diagnostic radiologic services. All radiologic services furnished by the REH must be provided by qualified personnel in accordance with state law and must not expose REH patients or personnel to radiation hazards. Like hospitals, CMS is also proposing to require that the REH must have radiologic services that meet the needs of their patients.
- CMS is proposing basic factors relating to safety hazard standards for patients and personnel.
- CMS is proposing to require that a qualified radiologist or other personnel qualified under state law either full-time, part-time, or on a consulting basis interpret radiologic tests that require specialized knowledge. This requirement can be fulfilled through arrangements with off-site providers via telehealth.

ACEP supports these proposals, as we appreciate that these requirements match those already instituted for CAHs.

Proposed Condition of Participation: Additional Outpatient Medical and Health Services

CMS is proposing that REHs be allowed to provide additional medical and health outpatient services that include, but are not limited to, radiology, laboratory, outpatient rehabilitation, surgical, maternal health, and behavioral health services. Further, CMS proposes to require that the provision of the additional service be based on nationally recognized guidelines and standards of practice. CMS further proposes to require that the REH have a system in place for referral from the REH to different levels of care, including follow-up care, as appropriate.

ACEP agrees that it may be appropriate for REHs to offer additional services—or at least have the ability to transfer patients to other facilities that can provide needed treatment. For example, some REHs may not have the capability of providing behavioral health services, but it is essential that they be able to transfer patients to inpatient psychiatric facilities. **Currently, "boarding" of patients with behavioral health and chemical dependency issues greatly stresses already limited staffing at rural EDs.** There is a lack of adequate security in these facilities to handle the occasional violent patient, and local law enforcement is often lean, leading to delays in responding to potential crises. These patients can be evaluated in a timely fashion by behavioral health care teams, either in-person or via telehealth, but disposition from the ED for inpatient placement is a serious barrier to adequate and equitable care. **Beyond behavioral and mental health services, other services that REHs could provide include case management and social services; substance use disorder services (including detoxification, counseling, and medication-assisted therapy); and post-acute care and coordination.**

Overall, **if there are services that an REH cannot provide, these patients will need to be transferred to larger and/or urban hospitals or other facilities that can provide the needed care.** EMS services also need to have adequate capacity for anticipated transfer needs.

CMS is also proposing that REHs provide maternal health services that include prenatal care, low-risk labor and delivery, and postnatal care. ACEP believes, **at a minimum, a CoP for REHs should require emergency clinicians to be able to recognize and initiate treatment of preeclampsia, miscarriage, and postpartum depression, as well as precipitous deliveries and common delivery complications such as shoulder dystocia**

and postpartum hemorrhage. Over the last decade, we have seen a substantial reduction in maternity care services within rural communities to the extent that maternity care deserts have been developing and expanding. This is one reason why the maternal and infant mortality rate has increased over the same time frame. That increase in mortality has impacted rural communities in particular, especially those with higher percentages of minorities.[2] Many pregnant women living in rural communities without maternity care will delay travel for delivery as long as possible due to concerns about childcare and work. At distances greater than 60 miles, there are significant increases in preterm delivery, poorer outcomes, and delivery in non-ideal settings en route to the planned delivery site. Therefore, comprehensive maternal health care is imperative as a condition of participation for REHs.

REHs will definitely see patients who require maternity care, including those with obstetrical emergencies. If CMS finalizes insufficient staffing supervision requirements for REHs, it could negatively impact the ability to respond to an obstetrical crisis. Further, small numbers of cases will make maintaining competence more difficult. All emergency staff need to be trained in the use of equipment and medications for obstetrical emergencies, which should be placed in easily identifiable carts. Team-based simulation can compensate for low number of potential cases in order to help maintain competency.

With respect to behavioral health services, CMS is proposing that REHs have the option to be opioid treatment providers as long as the treatment remains an outpatient service. **ACEP strongly believes in the use of buprenorphine to treat opioid use disorder (OUD).** However, REHs may not necessarily need to have opioid treatment programs in place to administer buprenorphine. We have seen great results with utilizing buprenorphine in the ED to help start patients on the path towards recovery. Initiating medication assisted treatment (MAT) in the ED helps individuals stay in treatment longer, reduces illicit opioid use and infectious disease transmission, and decreases overdose deaths.[3] In addition, the available data demonstrate that patients with opioid use disorder (OUD) who are started on buprenorphine in the ED – and for whom there is a clinic to maintain treatment after treatment in the ED – are twice as likely at 30 days to remain in treatment for OUD than patients who receive a referral alone (78 percent of patients started on MAT in the ED remain in treatment at 30 days, compared to only 37 percent of those who receive a referral alone).[4] Substantially increased participation in MAT after ED buprenorphine initiation has been replicated in additional studies.[5][6]

Furthermore, studies of patients with OUD in California and elsewhere have demonstrated an instantaneous reduction in mortality after buprenorphine-assisted detoxification, justifying its use in the ED even when access to long-term maintenance and follow-up is not available.[7] Finally, a study conducted using a retrospective chart review of 158 patients treated at a single ED with buprenorphine for opioid withdrawal found a greater than 50 percent reduction (17 percent versus 8 percent) in return-visit rate to the same ED for a drug-related visit within one month,

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[2] Health Resources and Services Administration. *Maternal and Obstetric Care Challenges in Rural America.* May 2020. https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/publications/2020-maternal-obstetric-care-challenges.pdf.

[3] Bao YP, Wang RJ, et al. Effects of medication-assisted treatment on mortality among opioids users: a systematic review and meta-analysis. Mol Psychiatry. 2018 Jun 22.

[4] D'Onofrio G, O'Connor PG, Pantalon MV, et al, JAMA. 2015 Apr 28;313(16):1636-44.

[5] Kaucher K, Caruso E, Sungar G, et al. Evaluation of an emergency department buprenorphine induction and medication-assisted treatment referral program. Am J Emerg Med. 2019 Jul 30.

[6] Hu T, Snider-Adler M, Nijmeh L, Pyle A. Buprenorphine/naloxone induction in a Canadian emergency department with rapid access to community-based addictions providers. CJEM. 2019 Jul;21(4):492-498.

[7] Elizabeth Evans et al., "Mortality Among Individuals Accessing Pharmacological Treatment for Opioid Dependence in California, 2006-10," Addiction 110, no. 6 (June 2015): 996-1005.

compared to the return-visit rate after usual care.[8] In all, research suggests that the sooner we can start patients on the right path, and keep them engaged in treatment, the more successful their recovery can be.

Despite the effectiveness of utilizing buprenorphine for treatment purposes, there are currently significant barriers to its use—the greatest of which is the "X-waiver" requirement mandated by the Drug Addiction Treatment Act (DATA) of 2000. Under the DATA 2000 law, physicians wishing to prescribe buprenorphine outside of opioid treatment programs (OTPs) must apply for a waiver through the Substance Abuse and Mental Health Services Administration (SAMHSA) and subsequently receive a license number through the Drug Enforcement Administration (DEA). While ACEP appreciates that the U.S. Department of Health and Human Services (HHS) released practice guidelines[9] that eliminate the training requirements for clinicians who treat fewer than 30 patients at one time, we firmly believe that the continued presence of this X-waiver requirement has led to misperception about MAT and has increased stigma about OUD and the treatment of this disease. Due to the stigma, some clinicians are not willing to pursue this DEA license or even engage in treatment of patients with OUD. ACEP supports the "Mainstreaming Addiction Treatment (MAT) Act," which would fully eliminate the X-waiver requirement.

CMS proposes personnel requirements for REHs who choose to provide additional outpatient medical and health services. ACEP believes, similar to the CoP for emergency services, that all care delivered in REHs should be overseen by physicians who have the appropriate expertise in the field.

Finally, CMS set forth standards for an REH performing outpatient surgical services that are consistent with the CAH requirements for surgical services. ACEP believes it is most appropriate for physicians who are trained surgeons to perform outpatient, non-emergency surgical procedures in REHs.

Proposed Condition of Participation: Infection Prevention and Control and Antibiotic Stewardship Programs

CMS is proposing a CoP for infection prevention and control and antibiotic stewardship programs for REHs that mirrors similar infection prevention and control requirements for hospitals and CAHs. REHs also must have facility-wide infection prevention and control and antibiotic stewardship programs that are coordinated with the REH quality assessment and performance improvement (QAPI) program, for the surveillance, prevention, and control of HAIs and other infectious diseases and for the optimization of antibiotic use through stewardship. CMS proposes requirements for these programs in the rule.

ACEP supports these proposals, as we appreciate that these requirements match those already instituted for CAHs.

Proposed Condition of Participation: Staff and Staffing Responsibilities

ACEP has multiple concerns, questions, and requests for clarification around this CoP.

Staffing the REH

CMS is proposing that REHs "should have the flexibility to determine how to staff the emergency department at the

[8] Berg ML, Idrees U, Ding R, Nesbit SA, Liang HK, McCarthy ML. Evaluation of the use of buprenorphine for opioid withdrawal in an Emergency Department. Drug Alcohol Depend. 2007;86:239-244.
[9] 86 FR. 22439. (April 28, 2021).

REH 24 hours, 7 days a week," and does not believe that it is necessary to have a physician, NP, CNS, or PA available to furnish patient care services at all times. Instead, CMS would allow a nursing assistant, clinical technician, or an emergency medical technician (EMT) to intake a patient who arrives at the REH and then contact an off-site practitioner of the patient's arrival. The physician, NP, CNS, or PA with training or experience in emergency care must be on call and immediately available by telephone or radio contact and available on site within specified timeframes.

ACEP strongly opposes this proposal and believes that if finalized, it would pose significant patient safety concerns. It could also increase the chances that REHs violate the Emergency Medical Treatment and Labor Act (EMTALA) if a trained clinician is unable to arrive in time to perform a medical screening examination and stabilize the patient if the patient has an emergency medical condition. While it may not be possible to have a board-certified emergency physician or other physician experienced and/or trained in emergency medicine (such as a family physician) staffing some REHs at all times, it is imperative that any time a patient comes to an REH with an immediate medical emergency, there will be clinician onsite to treat them IMMEDIATELY.

Supervision Requirements

We are also concerned that CMS does not specify supervision requirements of non-physician practitioners in this CoP. We therefore ask for clarification on whether REHs must comply with existing Medicare supervision requirements. The current outpatient supervision policy requires direct supervision of services furnished in a hospital or CAH, defined as a physician or non-physician practitioner being present on the same campus where services are being furnished, to be "immediately available" to furnish assistance and direction through the duration of the service. To comply with this policy, "immediate availability" requires the "immediate physical presence" of the supervisory physician or non-physician practitioner, such that they not be "so physically distant on-campus from the location where hospital/CAH outpatient services are being furnished that he or she could not intervene right away."

We would appreciate clarification on whether physicians could use telemedicine to satisfy the direct supervision requirement in REHs—a flexibility that has temporarily been in place during the COVID-19 public health emergency (PHE).

Clinicians "On Duty"

Further, CMS is proposing that a registered nurse, clinical nurse specialist, or licensed practical nurse be on duty whenever the REH has *one or more* patients receiving emergency services or observation care. By definition, the ED exists to treat those with acute, unscheduled emergent conditions. Therefore, ACEP seeks clarification on the rationale of requiring a practitioner to only be "on duty" when the REH has one or more patients receiving emergency services when the nature of EDs, open 24 hours a day, 7 days a week, necessitates constant availability of practitioners to deliver those services in case of immediate emergency. We also are concerned that CMS is including licensed practical nurses, who do not have as much training as registered nurses or CNSs and should therefore not be expected to be alone on duty in an REH unattended, into this category.

Clarification around Physician Requirements

CMS also includes a provision that a doctor of medicine or osteopathy "must be present for sufficient periods of

time" and be "available through direct radio or telephone communication or electronic communication for consultation, assistance with medical emergencies, or patient referral." We seek clarification on the specific definition of "sufficient periods of time" and being "present" in regard to physical presence or proximity to the campus in which emergency services are being furnished.

Medical Directors

CMS states that it is NOT proposing to require board-certified emergency physicians to serve as medical directors of the REH—as ACEP recommended in our response to the RFI. CMS agrees "that having a board-certified emergency physician serving as the medical director of the REH would benefit patients by ensuring that the REH is overseen by a highly qualified physician with a high level of expertise in emergency medicine" but believes "that requiring this of REHs would be unduly burdensome due to the challenges faced by rural communities in obtaining and retaining medical professionals to provide health care services." CMS does "encourage REHs to have such a physician serve in the capacity of medical director if possible."

ACEP appreciates that CMS understands the value of having board-certified emergency physicians serve as medical directors. Given the workforce challenges that exist in rural areas, ACEP understands that it may not be possible to have board-certified emergency physicians in this position in all REHs. However, we still strongly believe that, whenever possible, board-certified emergency physicians should serve in this role. When no board-certified emergency physicians are available, a physician with experience in emergency medicine, including family medicine-trained physicians, should serve as medical director. **Therefore, ACEP requests that CMS modify the CoP to make it a requirement that a physician with experience in emergency medicine serve as the medical director of a REH.**

Training and Education Requirements

While we recognize that the Consolidated Appropriations Act allows care in REHs to be delivered by non-physician practitioners and physicians without a board certification in emergency medicine, ACEP remains concerned about allowing non-physician practitioners to provide care without supervision given the lack of training and educational opportunities that are currently available. Surveys of rural EDs performed by ACEP found that the vast majority (about 85 percent) only required Advanced Cardiac Life Support (ACLS), Advanced Trauma Life Support (ATLS), and Pediatric Advanced Life Support (PALS) certifications, in addition to provider certification as a Medical Doctor (MD), Doctor of Osteopathy (DO), NP, or PA, in order to get credentialed to work in a rural ED.[10] This limited training is inadequate to work in any ED, much less as a solo provider in small rural EDs, where clinicians need strong skills and training to care for the broad range of emergency medical conditions they will likely face. **This CoP should therefore require a much more robust education, training, onboarding process than what currently exists.**

Proposed Condition of Participation: Discharge Planning

CMS proposes a series of discharge planning requirements that align with those required for CAHs and refers to previously issued guidance on providing discharge instructions in a culturally and linguistically appropriate manner.

[10] "ACEP Rural Emergency Care Task Force 2020 Report to the ACEP Board of Directors, October 2020, available at: https://www.acep.org/rural/rural-newsroom/rural-news-articles/january-2021/rural-task-force-summary/.

Discharge planning should focus on returning the patient to a home or community-based setting to the fullest extent possible with necessary supports and service.

ACEP agrees that it is extremely necessary to ensure a safe, well-coordinated discharge. ACEP developed an alternative payment model called the Acute Unscheduled Care Model (AUCM),[11] which the Physician-Focused Payment Model Technical Advisory Committee (PTAC) recommended to the HHS Secretary for full implementation. The AUCM provides incentives to participants to safely discharge Medicare beneficiaries from the ED by facilitating and rewarding post discharge care coordination. 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.

Under the AUCM, a Medicare beneficiary who presents to the ED will undergo a safe discharge assessment (SDA) concurrent to receiving clinical care to identify socioeconomic 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.

Overall, we believe that the model translates extremely well to the rural setting where it is very important to engage in post-discharge planning and care coordination to ensure that patients receive the follow-up treatment they need.

Proposed Condition of Participation: Patient's rights

CMS proposes a CoP for patient's rights that would set forth the rights of all patients to receive care in a safe setting and provide protection for a patient's emotional health and safety as well as their physical safety. Patients also have the right under the proposal to personal privacy, to receive care in a safe setting, and to be free from all forms of abuse or harassment, including relating to the use of restraints and seclusion, with staffing training requirements and death reporting requirements. Overall, the patient's rights CoP for REHs closely mimics the patient's rights CoP for hospitals.

ACEP supports these proposals as protections for patients' rights are essential to ensure that patients receive safe and high-quality care in REHs.

Proposed Condition of Participation: Quality assessment and performance improvement program (QAPI program)

CMS is proposing to require that every REH develop, implement, and maintain an effective, ongoing, REH-wide, data-driven QAPI program. The proposed QAPI program contains the following five parts: (a) Program and scope; (b) Program data collection and analysis; (c) Program activities; (d) Executive responsibilities; and (e) Unified and integrated QAPI program for an REH in a multi-hospital system.

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

[11] More information about the Acute Unscheduled Care Model (AUCM) can be found at https://www.acep.org/apm.

compared to patients receiving care in urban EDs.[12] However, a potential barrier to quality reporting that REHs may encounter is having access to the data they need to improve their quality performance and having the staff available 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.

Proposed Condition of Participation: Emergency Preparedness

CMS is proposing emergency preparedness requirements that align with the existing emergency preparedness standards for Medicare and Medicaid providers. As part of that approach, REHs must develop and maintain an emergency preparedness plan that must be reviewed and updated at least every 2 years. REHs must also develop and maintain an emergency preparedness training and testing program that is reviewed and updated at least every 2 years. REHs must conduct exercises to test the emergency plan at least annually. Specifically, REHs must conduct two testing exercises, a full-scale or functional exercise and an additional exercise of its choice, every 2 years.

In general, ACEP supports these proposals. As emergency physicians, we are on the frontlines responding to disasters and therefore recognize the necessity of planning for any kind of unexpected event. Having a comprehensive plan in place and training all staff about their responsibilities during an emergency is essential. As expected, we have found that the more intensive the training for these events, the more seamless the actual response.

With respect to training and testing requirements, ACEP strongly prefers comprehensive "boots on the ground" drills, as these are more effective than tabletop exercises or workshops.

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,

Gillian R. Schmitz, MD, FACEP

ACEP President

[12] 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.