

September 17, 2021

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

Re: CMS-1753-P

Re: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Radiation Oncology Model; Request for Information on Rural Emergency Hospitals Proposed Rule

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 Calendar Year (CY) 2022 Outpatient Prospective Payment System (OPPS) Proposed Rule, as some of the proposed policies and requests for information have a significant impact on our members and the patients we serve.

Request for Information on Rural Emergency Hospitals

In the rule, CMS seeks comments on a range of issues related to the creation of a new facility-type under Medicare called rural emergency hospitals (REHs), as 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 expanding access to emergency care in certain rural areas, especially those that have been impacted by recent hospital closures. As seen in our responses below, **we want to emphasize that in order to ensure the highest quality of care, all services delivered in REHs should be supervised by board-certified emergency physicians either in-person or virtually via telehealth.**

Type and Scope of Services Offered

- 1. What are the barriers and challenges to delivering emergency department services customarily provided by hospitals and CAHs in rural and underserved communities that may require different or additional CoPs for REHs (for example, staffing shortages, transportation, and sufficient resources):***

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Unfortunately, there are numerous barriers to providing equitable care in rural communities. Some of these barriers relate to:

- The inability to recruit qualified and sufficiently experienced, educated, and trained physicians, nurses, ancillary support staff, and other healthcare providers.¹ Despite a 28 percent increase in emergency medicine residency positions over the past 10 years^{2 3}, there has been no corresponding increase in emergency medicine residency trained or emergency medicine board certified physicians working in rural emergency departments (EDs).⁴
- Rural EDs, compared to their urban counterparts, are resource limited, financially stressed, and experience higher interfacility transfer rates.⁵
- The inconsistent use of technologies such as telehealth and inadequate broadband in rural areas; and
- Beneficiaries' inability to reach hospitals due to transportation issues. Emergency medical services (EMS) in rural areas also experience significant transportation delays due to issues with crew availability.

Given these challenges, ACEP believes that a condition of participation (CoP) for REHs should include:

- A standardized minimum level of education and training for all physicians, nurse practitioners (NPs), and physician assistants (PAs) working in REHs. As discussed in ACEP's response to questions 6 and 7, the COP should build off the COP § 485.618 for CAHs but also establish additional requirements to ensure that clinicians working in REHs have as much training as those working in urban EDs.
- Installation and maintenance of virtual platforms that support telehealth visits, consultations, and support.
- Collaboration and expansion of regional EMS systems to allow better availability for transfer of critically ill patients to receiving hospitals (typically urban).
 - There needs to be mechanisms to support the additional staffing, equipment, and training needs as EMS agencies are forced to adapt to more interfacility transfers that encompass greater distances.
 - EMS agencies will also need additional capacity to take some patients from scenes to more distant hospitals as REHs drop inpatient services.
 - CMS could also consider encouraging rural communities to engage in community paramedicine to help reduce unnecessary transports.
- Establishment of board-certified emergency medicine physicians as medical directors of all REHs so emergency care can be better standardized and educational and training standards can be assured.
- Establishment of an accreditation process for REHs to ensure that all REHs have proper equipment, adequately trained clinicians, in-person or telehealth consultative medical, surgical, and behavioral

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/>.

² Bennett CL, Sullivan AF, Ginde AA, et al. National study of the emergency physician workforce, 2020. *Ann Emerg Med* 2020; Published July 31, 2020. <https://doi.org/10.1016/j.annemergmed.2020.06.039>

³ U.S. Department of Agriculture: Economic Research Service. Urban Influence Codes. Available at: <https://www.ers.usda.gov/data-products/urban-influence-codes.aspx>. Accessed: October 1, 2020.

⁴ Bennett et al.

⁵ Kaufman BG, Thomas SR, Randolph RK, Perry JR, Thompson KW, Holmes GM, Pink GH. The Rising Rate of Rural Hospital Closures. *J Rural Health*. 2016 Winter;32(1):35-43. doi: 10.1111/jrh.12128. Epub 2015 Jul 14. PMID: 26171848.

services, pharmacist support, respiratory therapy support, adequate lab and imaging services, and proper nursing coverage.

2. *An REH must provide emergency and observation services and may elect to provide additional services as determined appropriate by the Secretary. What other outpatient medical and health services, including behavioral health services, should the Secretary consider as additional eligible services? In particular, what other services may otherwise have a lack of access for Medicare beneficiaries if an REH does not provide them?*

As is the case in most of our country, individuals living in rural areas have a vast array of medical conditions. Therefore, ACEP believes 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, others 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 a 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.

3. *What, if any, virtual or telehealth services would be appropriate for REHs to provide, and what role could virtual care play in REHs?*

Telehealth will be one of the cornerstones of ensuring patient safety at REHs, particularly those that are limited in staffing with only NPs and PAs available on-site. ACEP understands that it may not be possible to have a board-certified emergency physician in place at some REHs. We also recognize (but do not support) that the Consolidated Appropriations Act allows care in the REHs to be delivered by non-physician practitioners and physicians without a board certification in emergency medicine. **However, we strongly believe that in REHs that do not have board-certified emergency physicians on-site, telehealth should be used to ensure that these physicians oversee all services that are delivered. Without such supervision, it may be impossible to guarantee that patients receive high-quality care.**

There is currently no adequate required educational standard for non-emergency medicine trained physicians, NPs, and PAs to practice in EDs, despite the fact that the current CoP for critical access hospitals (CAHs) require emergency services to be performed by “a doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or clinical nurse specialist, **with training or experience in emergency care**”⁶ (emphasis added). 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

⁶ § 485.618 Condition of participation: Emergency services, available at: <https://www.law.cornell.edu/cfr/text/42/485.618>.

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.⁷ This limited training is inadequate to work in any ED, much less as a solo provider in a small rural EDs, who need strong skills and training to care for the broad range of emergency medical conditions they will likely face. A CoP for REHs should therefore require a much more robust education, training, onboarding process than what currently exists.

Whether in-person or via telehealth, emergency medicine-trained and -boarded physicians should render a complete medical screening exam— as required by the Emergency Medical Treatment and Labor Act (EMTALA)— at REHs so appropriate triaging can take place and the emergency physician can oversee the prioritization of care provided and assure the proper care and disposition of all patients. This approach would allow for emergency physicians to provide oversight at several hospitals simultaneously, overseeing NPs, PAs, and non-emergency medicine trained physicians providing independent care in REHs, and could help to mitigate the overall access issues due to workforce shortages that so many rural areas face.

Virtual specialist consultations should also be highly encouraged as part of a CoP, to help appropriately triage and disposition patients in the effort to minimize and avoid unnecessary transfers to larger regional hubs sites. Remote emergency medicine observation units or 24-hour decision-making units with support from cross trained nurses with hospitalists and/or specialist consultation capabilities could also improve the ability to provide local service without transport for clinical condition where less than 24 hours of patient care is anticipated.

4. Should REHs include Opioid Treatment Programs, clinics for buprenorphine induction, or clinics for treating stimulant addiction in their scope of services? Please discuss the barriers that could prevent inclusion of each of these types of services.

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.⁸ 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).⁹ substantially increased participation in MAT, after ED buprenorphine initiation has been replicated in additional studies.^{10,11}

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

⁷ “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/>.

⁸ 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.

⁹ D'Onofrio G, O'Connor PG, Pantalon MV, et al, *JAMA*. 2015 Apr 28;313(16):1636-44.

¹⁰ 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.

¹¹ 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.

to long-term maintenance and follow-up is not available.¹² 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-rate to the same ED for a drug-related visit within one month, compared to the return-visit rate after usual care.¹³ 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 OTPs must apply for a waiver through the Substance Abuse and Mental Health Services Administration (SAMSHA) 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 guidelines¹⁴ 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.

5. *What, if any, maternal health services would be appropriate for REHs to provide and how can REHs address the maternal health needs in rural communities? What unique challenges or concerns will the providing of care to the maternal health population present for an REH?*

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.¹⁵ 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.

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. With obstetrical emergencies there is often not enough time for transfer and a substantial risk to mother and baby during the transfer.

At a minimum, a CoP for REHs should require emergency clinicians to be able to recognize and initiate treatment of preeclampsia, miscarriage, postpartum depression as well as precipitous

¹² 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.

¹³ 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.

¹⁴ 86 FR. 22439. (April 28, 2021).

¹⁵ 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>.

deliveries and common delivery complications - such as shoulder dystocia and postpartum hemorrhage. REHs also need to have equipment and medications for obstetrical emergencies and need to be placed in easily identifiable carts. All emergency staff need to be trained in their use. Team-based simulation can compensate for low number of potential cases in order to help maintain competency.

There is also a need for prenatal care in rural areas. In the absence of other sources of prenatal care, offering prenatal care outreach as part of the REH would be appropriate.

Health and Safety Standards, Including Licensure and Conditions of Participation

6. The statute requires that REHs meet the requirements for emergency services (set forth at § 485.618) that apply to CAHs. Which hospital emergency department requirements (set forth at § 482.55) should or should not be mandated for REHs and why or why not? Are there additional health and safety standards that should be considered? What are they, why are they important, and are there data that speak to the need for a particular standard?

As background, the § 482.55 CoP requires EDs to have adequate staff to meet the anticipated needs of the community, and emergency services must be organized and supervised by a qualified member of the medical staff. The § 485.618 CoP requires that adequate basic emergency equipment be available, including supplies commonly used in life-saving procedures, e.g., oral airways, endotracheal tubes, ambu bag/valve/mask, oxygen, tourniquets, immobilization devices, nasogastric tubes, splints, IV therapy supplies, suction machine, defibrillator, cardiac monitor, chest tubes, and indwelling urinary catheters. Additionally, standard blood and blood products are required. Both COPs, with some modifications described below, should also be put in place for REHs.

Additional equipment that should be added as part of a CoP for REHs and rural EDs are video laryngoscopes for endotracheal intubation, various trays for venous and arterial vascular access and chest tube placement, and an emergency ultrasound machine. 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.¹⁶ This additional equipment should be part of a CoP for REHs.

Regarding medical staffing, the CoP for § 485.618 states that there must be a MD, DO, PA, NP, or a clinical nurse specialist, with training or experience in emergency care. This requirement should also apply to REHs as a CoP, but as alluded to earlier, should be modified to require that board-certified emergency physicians oversee all emergency care provided in REHs. **Emergency patients represent some of the most complex and critically ill patients in medicine and effective management of these patients requires years of specialized training. There are no physician residencies that afford this specialized training other than emergency medicine.** Further, PA and NP programs are extremely abbreviated compared to medical training 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.

¹⁶ “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/>.

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	<u>21 hours, 820 questions:</u> - 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 non-emergency medicine-trained physicians, PAs, and NPs 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 to have access to a specialist in emergency medicine.

7. *The REH must meet staff training and certification requirements established by the Secretary. Should these be the same as, or similar to, CAH requirements (Personnel qualifications, §485.604 and Staffing and staff responsibilities, §485.631)? Are there additional or different staff training and certification requirements that should be considered for REHs and why? Are there any staffing concerns that the existing CAH requirements would not address?*

Currently, there are a broad range of competencies of clinicians that care for patients in the wide variety of types of rural EDs that have vastly different volumes and clinical settings. As stated earlier, there is a lack of a consistent onboarding educational process or any adequate minimum threshold of training for providers to work safely in rural EDs. There is no specialty, other than emergency medicine, that prepares physicians to practice safely in rural EDs. More concerning is the fact that non-physicians have also moved into this space and have begun to work as solo practitioners in very low volume EDs. Many have taken it upon themselves to get adequate training at a high-volume ED before moving to the rural setting. Not only should REHs have a requirement for adequate education and training, as CAHs currently have, but all rural hospitals need to develop a minimum standard for training. ACEP is currently developing accreditation standards for all EDs that may include such a training standard. Again, telehealth support by emergency physicians for non-emergency medicine trained physicians, NPs, and PAs should also be part of a CoP for REHs so a similar standard of emergency care can be established for rural patients as it already exists for urban patients.

Regarding nursing staff training, all REH nursing and ancillary staff should meet the same standard of education as do their urban counterparts. Surges in volumes and the care of critically ill patients requires that all REH staff be fully trained, as backup staff are not readily available. Registered nurses in REHs should receive Certified Emergency Nurse (CEN) training and certification.

8. *What additional considerations should CMS be aware of as it evaluates the establishment of CoPs for REHs? Are there data and/or research of which we should particularly be aware?*

According to a 2020 report by the U.S. Government Accountability Office (GAO), more than 100 rural hospitals have closed since 2013.¹⁷ The closure of a rural hospital or CAH can have a rippling effect through a community. REHs need to replace existing CAHs and other rural EDs, not duplicate their services, and need to weigh the benefit of cost savings with loss of inpatient healthcare convenience and loss of jobs in the community. A CoP for REHs needs to include requirements for providing short-term observation admissions, and funds will need to be allocated to support sufficient nursing staff to cover this service. REHs will also need a supply of medications for clinicians to dispense for short-term use until patients can get to a local pharmacy. The CoP for equipment should be the same as that for CAHs. Every rural situation will be unique and the value of the current CAH will need to be weighed against the transition to a REH.

Creating a more integrated health system should be one of the primary goals of moving to REHs. A CoP for REHs needs to include a requirement for collaborative agreements with larger health systems/hospitals. These larger institutions will need to either take over the management of the REH or closer affiliate with the REH so patients can receive more comprehensive care and higher quality care immediately, when the emergency occurs. Specialty surgery should be performed at large centers of excellence, and this is a reason why an REH may be preferable over a CAH. CAHs often depend on their surgical cases to be the primary driver of financial viability.

Under current reimbursement models, ED evaluation and management (E/M) codes would not likely cover the cost of a REH and its services in most circumstances. Though there can be substantial savings to the health system by consolidating regional inpatient beds, current billing and coding would not be sufficient to provide proper staffing and services of a REH. There are fixed costs that cannot be eliminated by converting a CAH to a REH. These include: lab and imaging services, ED nursing and support staff, security staff, medical record services and other IT services, and maintenance personnel. When looking at the potential financial advantage of converting a CAH to a REH, one needs to look beyond the savings just at that facility and look at potential savings and efficiency to the entire health system, and the improvement of equitable care for rural patients.

Finally, alcohol-related emergencies can also overwhelm small EDs. Separate county detoxification services should be expanded as a CoP for converting CAHs to REHs, and local law enforcement should provide transport to these facilities once patients are medically cleared in the REH.

9. *What, if any, lessons have been learned as they relate to rural emergency services during the COVID-19 pandemic that might be pertinent to consider for policy implementation after the Public Health Emergency?*

There has been a significant increase in the use of telehealth services in emergency medicine during the COVID-19 public health emergency (PHE). CMS has taken numerous steps to expand the use of telehealth under Medicare, and many have argued that our nation will never go back to a “pre-COVID” world where telehealth services were rarely performed or accessible. While CMS has made substantial changes to telehealth policies, there are a few that particularly impact emergency medicine. The most significant policy, which impacted all

¹⁷ U.S. Government Accountability Office, “Rural Hospital Closures: Affected Residents Had Reduced Access to Health Care Services,” December 2020, available at: <https://www.gao.gov/assets/gao-21-93.pdf>.

telehealth services, has been CMS' use of its 1135 waiver authority to temporarily waive the originating site and geographic restrictions, allowing health care practitioners to provide telehealth services to patients regardless of where the clinicians or the patients are allocated. Further, CMS clarified that medical screening exams (MSEs), a requirement under the EMTALA could be performed via telehealth. Finally, CMS temporarily added all five ED E/M codes, some observation codes, and critical care codes to the list of approved Medicare telehealth services on a Category 3 basis.

These policies have been critically needed as emergency physicians continue to respond to the pandemic. Being able to perform MSEs via telehealth has helped protect emergency physicians from unnecessary exposure to the virus and has helped preserve the supply of personal protective equipment. Further, having the ED E/M codes on the approved list of Medicare telehealth services has helped provide an appropriate and sustainable reimbursement mechanism for emergency telehealth programs during the pandemic. **Once the pandemic is over, CMS should consider keeping these telehealth flexibilities in place for REHs.**

In addition, during the COVID-19 pandemic, it has been more important than ever for rural hospitals to collaborate with larger, urban hospitals by sharing patient care protocols and doing virtual specialty consultations. Overall, establishing and updating specific care plans, communicating with experts via telehealth, and creating predetermined transfer plans are essential for optimal and equitable care of rural patients—especially during a pandemic.

10. Are there state licensure concerns for hospitals and CAHs that wish to become REHs? What issues with respect to existing or potential state licensure requirements should CMS consider when developing the CoPs for this new provider type? What supports and timelines should be in place for States to establish licensing rules?

Issues regarding state licensure will vary to some degree depending on the state in which a small rural hospital or CAH is converting to a REH. Minnesota, for example, requires all hospitals that intend to close or eliminate service lines of obstetrics, mental health, substance abuse, and/or ICU, must notify the department of health and provide a 120-day notice. Laws such as these could significantly delay the REH conversion timeline.

Furthermore, there should be consistency among states regarding licensure for telehealth services.¹⁸ **All states should employ similar waivers that they had in place during the COVID-19 PHE and allow providers to provide telehealth services across state lines.**

Health Equity

11. How can REHs address the social needs arising in rural areas from challenging social determinants of health, which are the conditions in which people are born, live, learn, work, play, worship, and age, and which can have a profound impact on patients' health, ensuring that REHs are held accountable for health equity?

As emergency physicians, we see patients from all backgrounds who have various social risk factors—and in rural areas, individuals have a broad range of underlying physical, social, and emotional factors that impact their overall health. Patients in rural areas are especially vulnerable, suffering from higher age adjusted mortality,

¹⁸ A comprehensive list of state licensure waivers during the COVID-19 public health emergency is available at: <https://www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-covid-19.pdf>.

greater rates of chronic disease, increased high risk behaviors, and decreased life expectancy when compared to urban patients.¹⁹

There are many interventions that are currently being employed in EDs to help identify barriers to health such as transportation and access to food and housing. One such tool that ACEP supports to help manage care for patients with complex needs is the Collective Medical Technologies' (CMT) Edie™ (a.k.a. PreManage ED) software. Edie™ is an information exchange that provides critical information on patients, such as how many ED visits patients have had in the last year, where they presented, their drug history, other providers who are involved with the patients, and finally, whether there is a patient-specific care management plan that could guide treatment. The platform improves patient care by allowing emergency physicians to make more informed clinical decisions and better direct a patient's follow-up care. It also lowers health care costs through a reduction in redundant tests and through better case management that reduces hospital readmissions. Through an alliance with CMT, ACEP has seen this system mature in approximately 17 states. Washington state, in the first year alone, experienced a 24 percent decrease in opioid prescriptions written from emergency departments, a 14 percent reduction of super-utilizer visits, and state Medicaid savings of more than \$32 million.²⁰

Some EDs across the country are attempting to create care coordination and case management programs that help improve follow-up appointment scheduling from the ED and target social interventions and primary medical care to high ED utilizers. One such program in Maryland applies mobile technology to use paramedics in a community health worker role to follow up on discharged patients at risk for readmission.²¹ Many of these patients are Medicare beneficiaries. Another program in the East Bay, California has a help desk for health-related social needs with four integrated medical-legal partnerships, called Health Advocates, to help patients navigate housing and transportation challenges, immigration challenges, and benefit eligibility.²²

ACEP is continuing to explore other innovative ways our physicians can help coordinate care for high-risk patients, including through participation in alternative payment models (APMs). ACEP has developed an APM called the Acute Unscheduled Care Model (AUCM)²³, 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. We believe that this 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.

¹⁹ Moy E, Garcia MC, Bastian B, Rossen LM, Ingram DD, Faul M, Massetti GM, Thomas CC, Hong Y, Yoon PW, Iademarco MF. Leading Causes of Death in Nonmetropolitan and Metropolitan Areas- United States, 1999-2014. *MMWR Surveill Summ*. 2017 Jan 13;66(1):1-8. doi: 10.15585/mmwr.ss6601a1. Erratum in: *MMWR Morb Mortal Wkly Rep*. 2017 Jan 27;66(3):93. PMID: 28081058; PMCID: PMC5829895.

²⁰ <https://www.acepnow.com/article/emergency-department-information-exchange-can-help-coordinate-care-highest-utilizers/2/>

²¹ For more information on the Maryland Mobile Integrated Health Care Programs, please go to <https://www.miemss.org/home/LinkClick.aspx?fileticket=w-K7gG-8teo%3D&tabid=56&portalid=0&mid=1964>

²² For more information on the Health Advocates Program, please go to <http://www.levittcenter.org/ed-social-welfare-in-collabor/>.

²³ More information about the Acute Unscheduled Care Model (AUCM) can be found at <https://www.acep.org/apm>.

12. *With respect to questions 1 through 11 above, are there additional factors we should consider for specific populations including, but not limited to, elderly and pediatric patients; homeless persons; racial, ethnic, sexual, or gender minorities; veterans; and persons with physical, behavioral (for example, mental health conditions and substance use disorders), and/or intellectual and developmental disabilities?*

As required by law, REHs will see any patient at any time— and in doing so—ACEP strongly believes that REHs have an essential responsibility to promote health equity within the communities they serve. **That is a core part of ACEP’s mission, as one of our policies advocates “...tolerance and respect for the dignity of each individual and opposes all forms of discrimination against and harassment of patients and emergency medicine staff on the basis of an individual’s race, age, religion, creed, color, ancestry, citizenship, national or ethnic origin, language preference, immigration status, disability, medical condition, military or veteran status, social or socioeconomic status or condition, sex, gender identity or expression, sexual orientation, or any other classification protected by local, state or federal law.”**²⁴

In order to successfully adhere to this core mission, REHs will need to have the tools and resources to treat vulnerable populations. The COVID-19 pandemic has truly demonstrated how underlying disparities in health care access among certain populations affected outcomes, as there have been significantly higher rates of COVID-19 infection and mortality in Latino/Hispanic and African American populations. Some of this trend stems from individuals having comorbidities that may not be diagnosed or treated due to limited access to primary care.²⁵ **REHs serving these populations may need to provide additional case management and social services to help address the underlying social factors that greatly impact their patients. REHs will also need to have the infrastructure in place to be able to connect patients with appropriate follow-up services with primary care physicians or specialists or subspecialists if available.**

In addition, ACEP believes that some REHs that are in communities with higher proportions of elderly patients should establish policies and protocols that support geriatric-specific emergency care. ACEP has developed an accreditation program for geriatric EDs, called the Geriatric Emergency Department Accreditation Program (GEDA).²⁶ REHs can use the GEDA standards as a framework for implementing procedures that would improve care for seniors in such communities.

With respect to patients with mental health disorders, as alluded to in the response to question 2, REHs could either provide behavioral health services directly or have the capability to transfer patients directly to inpatient psychiatric facilities.

Finally, we strongly believe that the X-waiver requirement for prescribing buprenorphine needs to be eliminated to ensure that all emergency clinicians are able to appropriately treat patients with opioid use disorder.

²⁴ ACEP Non-Discrimination and Harassment Policy, available at: <https://www.acep.org/patient-care/policy-statements/non-discrimination-and-harassment/>.

²⁵ ACEP COVID-19 Field Guide, “Racial and Ethnic Minority Groups.” Available at <https://www.acep.org/corona/covid-19-field-guide/special-populations/racial-and-ethnic-minority-groups/>.

²⁶ More information about GEDA can be found at: <https://www.acep.org/geda/>.

- 13. How can the CoPs ensure that an REH’s executive leadership (that is, its governance, or persons legally responsible for the REH) is fully invested in and held accountable for implementing policies that will reduce health disparities within the facility and the community that it serves? In addition, with regards to governance and leadership, how can the CoPs:**
- a. Encourage a REH’s executive leadership to utilize diversity and inclusion strategies to establish a diverse workforce that is reflective of the community that it serves;**
 - b. Ensure that health equity is embedded into a facility’s strategic planning and quality improvement efforts; and**
 - c. Ensure that executive leadership is held accountable for reducing health disparities?**

ACEP believes that REHs should attempt to put into place an executive leadership that reflects the racial and ethnic make-up of their communities. It is also important for the leadership to get input directly from patients and caregivers about what additional services REHs can provide to best meet the needs of the community and promote equitable care.

- 14. An important first step in addressing health disparities and improving health outcomes is to begin considering a patient’s post-discharge needs and social determinants of health prior to discharge from a facility. How can health equity be advanced through the care planning and discharge planning process? How can the CoPs address the need for REHs to partner with community-based organizations in order to improve a patient’s care and outcomes after discharge?**

Having a safe, well-coordinated discharge is extremely important. As discussed in our answer to question 11, ACEP’s AUCM model focuses on safely discharging Medicare beneficiaries from the ED. Under the model, a Medicare beneficiary who presents to the ED will undergo a safe discharge assessment (SDA) concurrent to receiving clinical care to identify socio-economic factors and potential barriers to safe discharge back to the home or community, needs related to care coordination, and additional assistance that may be necessary. If the participating emergency physician, in collaboration with the primary care physician or designated specialist, determines that the patient is a candidate for discharge, the information captured during the SDA will be used to generate unique patient discharge instructions including identifying symptoms that would require rapid reassessment and return to the ED. After the initial ED visit, the patient will receive appropriate follow-up care from the ED physician, his or her primary care physician, and other specialists as needed.

- 15. In order to ensure that health care workers understand and incorporate health equity concepts as they provide culturally competent care to patients, and in order to mitigate potential implicit and explicit bias that may exist in healthcare, what types of staff training or other efforts would be helpful?**

ACEP believes it is critically important to address the issue of implicit (unconscious) bias of physicians. Implicit bias may affect a physician’s clinical decision-making, which may have significant impacts on a patient’s outcome. ACEP offers a free online continuing medical education (CME) course to members, “Unconscious Bias in Clinical Practice,”²⁷ to help emergency physicians learn about the negative effects of unconscious or implicit bias in clinical scenarios, as well as learn how to employ strategies to minimize these effects. Among the objectives of this course is analysis of the link between social determinants of health, cultural competence, bias, and patient care. This course provides several examples of existing health disparities and how

²⁷ More information about the “Unconscious Bias in Clinical Practice” course can be found at: <https://www.acep.org/life-as-a-physician/why-does-diversity-matter/>.

implicit bias factors into these differences, including how Black patients are systematically undertreated for pain, are diagnosed as schizophrenic at disproportionately higher rates, and how differences in provider communication may contribute to an observed phenomenon that Black patients are more likely to die in the intensive care unit (ICU) relative to white Americans. The course offers strategies to help emergency physicians take action and implement practices to help recognize and reduce the effect of implicit bias in their clinical decision-making. Such courses could be incorporated into the CoPs of REHs.

16. Finally, how can the CoPs ensure that providers offer fully accessible services for their patients in terms of physical, communication, and language access with the resources they have available to them?

As stated in the response to question 12, REHs will need additional tools and resources to fully meet the needs of their patient population. Having staff—even available only remotely—who are able to help reduce any communication or language barriers to care (such as translators) would be extremely beneficial.

Collaboration and Care Coordination

17. How can CMS and other Federal agencies best encourage and incentivize collaboration and coordination between an REH and the healthcare providers, entities, or organizations with which an REH routinely works (for example, requirements related to the Emergency Medical Treatment and Active Labor Act, transfer agreements, and participation in EMS protocols), to help the REH successfully fulfill its role in its community? Healthcare providers, entities, and organizations with which an REH might typically work and interact might include, for example, federally qualified health centers, rural health clinics, state and local public health departments, Veterans Administration and Indian Health Service facilities, primary care and oral health providers, transportation, education, employment and housing providers, faith-based entities, and others.

To meet the obligations under EMTALA, larger hospitals in urban areas usually accept rural ED transfers. Both facilities have an incentive to communicate about this relationship ahead of needing to transfer patients. Thus, in many cases, a coordinated and efficient system exists.

However, ACEP does believe that additional incentives and payment waivers will be necessary to incentivize care coordination. ACEP's AUCM model specifically fosters care coordination by holding emergency physician groups accountable for the cost and quality of care Medicare beneficiaries receive over a 30-day period for specific episodes of acute unscheduled care. The model includes payment waivers for ED acute care transition services, telehealth services, and post discharge home visits. The waivers provide emergency physicians with the necessary tools to better coordinate care and promote improved patient outcomes. Further, as described our response to questions 11 and 14, an emergency medicine healthcare professional will administer an SDA to identify socio-economic factors and potential barriers to safe discharge, needs related to care coordination, and additional assistance that may be necessary. Information captured in the SDA informs unique patient care instructions provided at the time of discharge. The emergency physician participates in shared decision-making by coordinating with the primary care physician or specialist assuming care of the patient after ED discharge. Finally, the ED group arranges follow-up services by telephone, in-person visits, or telehealth outreach.

Quality Measurement

18. What existing quality measures that reflect the care provided in rural emergency department settings can be recommended? What existing quality measures from other quality reporting programs, such as the Hospital Inpatient Quality Reporting and Hospital Outpatient Quality Reporting Programs, are relevant to the services that are likely to be furnished in REHs and should be considered for adoption in the REH context? What measures, specific to REHs, should be developed?

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.²⁸ Therefore, it will be important that CMS establish a core set of measures that help REHs focus on improving patient outcomes.

Since REHs will be providing emergency and other outpatient services, ACEP believes that the Hospital Outpatient Quality Reporting Program's measure set is an appropriate source of measures that CMS can use to start building an REH quality program. We reviewed the current measures in the Hospital Outpatient Quality Reporting Program and believe that the following measures are relevant for REHs:

- OP-2: Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival
- OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
- OP-10: Abdomen CT—Use of Contrast Material
- OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients
- OP-22: Left Without Being Seen
- OP-23: Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival

ACEP especially supports 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.

Further, CMS could consider measures that are valid and reliable even with lower volumes of patients and measures that address care transitions. A National Quality Forum report from 2018 also developed a core set of rural health measures that focused on mental health, substance abuse, medication reconsolidation, diabetes, hypertension, and chronic obstructive pulmonary disease (COPD), and perinatal and pediatric conditions and services.²⁹

19. Based on experiences in quality reporting by small rural hospitals and CAHs, what barriers and challenges to quality reporting are REHs likely to encounter? What quality reporting strategies should CMS consider to mitigate those barriers?

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.

²⁸ 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.

²⁹ National Quality Forum. A Core Set of Rural-Relevant Measures and Improving Access to Care. 2018. Available at: https://www.qualityforum.org/Publications/2018/08/MAP_Rural_Health_Final_Report_-_2018.aspx.

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.

20. For CAHs, what are the barriers and challenges to electronic submission of quality measures, and will those barriers likely apply to REHs? What similar barriers and challenges could CAHs and REHs experience for chart abstracted measures?

The most common barriers to accurate and timely reporting of quality measures are the functionality of CAH's electronic health record (EHR) systems, and IT support for the information system to capture and report data. Development and implementation of a uniform reporting system (software) for all REHs would be helpful. Another barrier is the availability of trained professionals to evaluate medical records and accurately extract and report data in smaller communities and rural hospitals. Establishing regional networks of trained health information professionals who can work remotely and access hospital information systems would be a potential solution.

21. What factors should be considered for the baseline measure set and how should CMS assess expanding quality measures for REHs? How could quality measures support survey and certification for REHs?

REHs should initially have a limited number of quality measures on which they are required to report. As stated in our answer to question 18, we believe that CMS should start with a subset of measures in the Hospital Outpatient Quality Reporting Program. Over time, CMS could consider adding more measures. If new measures need to be developed, ACEP strongly believes that CMS should be fully responsible for funding the cost of the development and testing processes and not solely rely on outside entities, that may have more limited resources, to conduct this work.

22. What additional incentives and disincentives for quality reporting unrelated to payment would be appropriate for REHs? Are there limitations or lower limits based on case volume/mix or geographic distance that would be appropriate for CMS to consider when assessing the quality performance of REHs?

ACEP believes that there should be appropriate incentives for REHs to report quality data and improve their performance over time. However, quality improvement takes time, and as new facilities, REHs should not be held financially accountable for their quality performance initially. Therefore, ACEP recommends that CMS begin with a "pay for reporting" requirement for the first year or two of an REH being established and then move towards a "pay for performance" requirement. Other non-payment-related incentives/disincentives for quality reporting such as publicly reporting performance events could be used. However, as discussed in our answer to question 23, public reporting of REHs' performance scores also should not be implemented immediately.

23. The inclusion of CAHs within the Overall Hospital Quality Star Ratings provides patients with greater transparency on the performance of CAHs that provide acute inpatient and outpatient care in their area. What factors should CMS consider in determining how to publicly report REH quality measure data?

ACEP believes that REHs' quality performance scores should eventually be publicly reported like other hospitals. However, there should definitely be a grace period for these scores to be published publicly. In other words, once an REH begins to treat patient, it should have a least a year or two to get all its operations in place before its quality performance results are posted online. **Further, the performance scores should be risk-adjusted based on the patient populations the REH care for, including the complexity of cases and the social risk factors present among their patients.** In addition, if the REH is the only facility providing emergency care in a wide-spread geographic area, there could become issues with ED crowding or boarding—especially if the REH has insufficient staffing or bed capacity. These types of factors could impact patient satisfaction scores. CMS should find a way of flagging low performance scores on the Compare site that are due to factors beyond the control of REHs.

Payment Provisions

24. Under the law, only existing critical access hospital or subsection (d) hospitals with not more than 50 beds that are located in a rural area are eligible to convert to an REH. While REHs will receive the applicable OPPS rate that would otherwise apply under section 1833(t)(1) of the Act and with an increase of 5 percent under section 1834(x)(1) of the Act as well as an additional facility payment to be made on a monthly basis under section 1834(x)(2) of the Act, we note that rural sole community hospitals (SCHs) currently receive an additional 7.1 percent payment for all services paid through the OPPS. We are seeking comment on the likelihood of rural SCHs deciding to seek to become REHs.

ACEP has found that sole community hospitals (SCHs) are highly variable in their inpatient size and overall ED volume. Converting a failing small SCH with low inpatient and ED volumes to a REH could look very similar to converting a rural CAH to a REH and have similar impact on a community's access to care. In contrast, converting a larger SCH with significant inpatient capacity and specialty services to a REH could possibly have a negative impact on a rural community. In the interest of preserving the maximum amount of medical care in rural areas and avoiding any incentive to downsize the amount of care available, we should support the operation of SCHs in every way possible, including higher levels of reimbursement.

25. In order to calculate the additional annual facility payment for rural emergency hospitals required by section 1834(x)(2) of the Act, CMS will need to compare all CY 2019 payments to CAHs with an estimate of the total amount of payment that would have been made to CAHs in CY 2019 if CAHs were paid through the inpatient, outpatient, and skilled nursing facility prospective payment systems, rather than receiving Medicare payment at 101 percent of the reasonable costs of these services. Are there any claims or other payment reporting issues that CMS should consider when calculating the hypothetical estimated payment under the prospective payment systems for services furnished by CAHs in CY 2019?

ACEP does not have any proposed modifications to this methodology. However, we do note that even with these additional payments, REHs could still be underfunded. Rural communities have a higher burden of uninsured and underinsured patients as well as a high burden of disease. Even with existing cost-based reimbursement, many rural CAHs struggle to support their operations.

26. We also are seeking comment on whether the claims forms used by CAHs to report inpatient hospital services, outpatient hospital services, and skilled nursing services contain all of the necessary information in order that the claims could be processed by the applicable CMS prospective payment systems. We are seeking this information because section 1834(x)(2)(C) of the Act requires as a part of the calculation to determine the additional facility payment for CY 2023 for CMS to estimate what CAHs would have received for payment of inpatient hospital services, outpatient hospital services, and skilled nursing facility services if those services were paid through their respective prospective payment systems. We want to know what barriers, if any, we may face when attempting to use CAH claims to perform this calculation. If the CAH claims are missing information that would be required to process the claims through a prospective payment system, what challenges could CAHs face in collecting the missing information and submitting it to CMS for processing?

ACEP does not represent CAHs, so is unable to fully respond to this question. However, as emergency physicians working in rural areas (including in CAHs), we have noticed that in some cases, the cost-based reimbursement system has led to inaccurate accounting of what services are provided due to incomplete data on claims and a lack of information about secondary diagnoses, procedures, or other services. Increasing incentives for accurate reporting of these services and providing funding for the study of these costs and the optimal reimbursement strategy for these services would be beneficial.

27. The statute requires that a facility seeking to enroll as an REH must provide information regarding how the facility intends to use the additional facility payment provided under section 1834(x)(2) of the Act, including a detailed description of the services that the additional facility payment would be supporting, such as furnishing of telehealth and ambulance services, including operating the facility and maintaining the emergency department to provide covered services. What challenges will providers face to maintain and submit what will likely be similar detailed information about how their facility has spent the additional facility payment for rural emergency hospitals as required by section 1834(x)(2)(D) of the Act? What assistance or guidance should HHS consider providing to facilities to meet this reporting requirement?

One accounting challenge in small rural hospitals and CAHs is how to appropriately allocate costs. During the course of one day, a clinician working in a rural hospital or CAH could care for an ED patient, an inpatient, or a skilled nursing facility (SNF) patient and engage in other administrative duties such as managing inventory or clean equipment. Most REHs will likely be small facilities where it will be very difficult to allocate the cost of staff to specific activities. Therefore, ACEP recommends that the “information regarding how the facility intends to use the additional facility payment” should focus on how the payment was used to support REH operations as a whole and not on the cost of specific services or activities.

Enrollment Process

28. The statute requires that an eligible facility must submit an application to enroll as an REH in a form determined by the Secretary. In accordance with the requirements of the CAA, the application for enrollment must include an action plan for initiating REH services, including a detailed transition plan that lists the specific services that the facility will retain, modify, add and discontinue. What suggestions do facilities who are considering enrolling as REHs want us to take into account in developing the enrollment requirements?

It is important for CMS to recognize that there will be significant variation among different rural communities in terms of the types and volumes of services that are provided, the supply of providers, and the EMS overall organizational structure, capabilities, and resources. Thus, the enrollment requirements for REHs must be sufficiently broad and flexible to accommodate the diverse needs of rural communities.

29. What considerations should be taken into account regarding the steps and timing for conversion to an REH?

Conversion of a CAH to a REH requires significant time and capital, not only to complete all the necessary infrastructure changes and administrative work, but also to subsidize the hospital operations during this transition time when patient volumes are likely to drop and some services are permanently and temporarily unavailable. Low-cost capital should be available for conversion of these facilities including covering operating costs during the transition period. There is limited data on how long this transition may take, but we believe the transition time could take a couple of years.

Changes to the Inpatient Only List

In last year's OPSS rule, CMS proposed and finalized a policy that would eliminate the Inpatient Only (IPO) list over a three-year transitional period. CMS began with the removal of nearly 300 musculoskeletal-related services in 2021, which makes these procedures eligible to be paid by Medicare in the hospital outpatient setting in addition to the inpatient setting. Procedures removed from the IPO list are exempted from certain medical review activities related to the "two-midnight" rule policy.

CMS is now proposing to retract the policy and stop the elimination of the IPO list. CMS will add the nearly 300 services that were removed this year back on the IPO list beginning next year. CMS is reversing course to ensure that services that are removed from the IPO list going forward are appropriately reviewed against CMS' criteria for providing services in an outpatient setting. CMS is also seeking comment on whether the agency should consider eliminating the IPO list going forward. Furthermore, CMS is proposing to modify the two-midnight exemption policy it finalized last year— now requiring that all services paid for under the OPSS be eventually subject to medical review.

ACEP supports CMS' proposal to reverse its policy to eliminate the IPO list. We also do not think that CMS should introduce such a policy going forward. In ACEP's comments on the last year's rule,³⁰ we had expressed concerns about the effects that eliminating the IPO list would have on observation stay reimbursement policies. Observation stays have proven to be an excellent mechanism for ensuring that patients are not unnecessarily admitted to the hospital or prematurely sent home. Due to the safety and efficiency benefits of observation status, we have found that these claims are not subject to heavy audits for site-of-service review. However, the removal of the IPO list could result in an increased audit burden across the board as two-midnight case reviews increase. We had therefore asked CMS to more carefully consider the potential auditing and documentation burden on health care practitioners prior to finalizing any policy as significant as the complete elimination of the IPO list.

We also believed that other healthcare payors will use the lack of an IPO list as a tool to force cases that are appropriate for the inpatient setting into other places-of-service. While these are not procedures that would

³⁰ ACEP's comments on the CY 2021 OPSS proposed rule are available here: <https://www.acep.org/globalassets/new-pdfs/advocacy/acep-response-to-cy-2021-opss-proposed-rule.pdf>.

typically be conducted in EDs, if payors were to attempt to shift even a portion of the more than 1,700 cases into other places of service, the potential effects on outpatient departments, EDs, and observation units could be debilitating.

Hospital Quality Reporting Programs

CMS is seeking comment on a measure included in the Hospital Inpatient Quality Reporting (IQR) Program: the Safe Use of Opioids electronic clinical quality measure (eCQM). Hospitals are currently required to report three self-selected eCQMs from an established list of eCQMs as well as the Safe Use of Opioids eCQM. CMS wants feedback on whether the Safe Use of Opioids eCQM should be optional going forward (i.e., whether hospitals could also self-select this measure from the list of eCQMs).

The Safe Use of Opioids measure is a process measure that calculates the proportion of patients age 18 years and older who are prescribed two or more opioids or an opioid and benzodiazepine concurrently at discharge from a hospital-based encounter (inpatient and ED including observation stays). It was added to the list of required measures for the Hospital IQR program in the Fiscal Year (FY) 2020 Inpatient Prospective Payment System (IPPS) rule. In ACEP's comments on that rule³¹, we expressed significant concerns about including the measure in the Hospital IQR program—believing that the inclusion of the measure may have some inappropriate, unintended consequences. We stated that the measure could pose a potential bias against emergency physicians, who could, through no fault of their own, discharge a patient from the ED who has concurrent prescriptions of two unique opioids or an opioid and benzodiazepine written by another clinician unrelated and prior to the current ED visit. We also believed that the measure could jeopardize patient safety. Further, we believed that the presence of the measure in the Hospital IQR Program could incentivize clinicians to abruptly cease a patient's established medications during emergency situations, which could potentially result in the undertreatment or mistreatment of pain or development of withdrawal syndromes.

ACEP continues to have the same concerns about the Safe Use of Opioids measure and requests that it be optional and not required going forward.

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,



Mark S. Rosenberg, DO, MBA, FACEP
ACEP President

³¹ ACEP's comments on the FY 2020 IPPS proposed rule are available at: <https://www.acep.org/globalassets/new-pdfs/advocacy/acep-response-to-fy-2020-ippa-proposed-rule.pdf>.