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November 16, 2018

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8010
Baltimore, MD 21244-1810

Re: CMS-3346-P

Re: Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction

Dear Administrator Verma:

On behalf of over 39,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on a proposed rule that aims to reduce regulatory burden on providers. ACEP supports the Administration's overall goal to eliminate unnecessary documentation requirements, but at the same time, we want to make sure that any possible changes do not have any unintended consequences that could pose a detrimental impact on the patients we serve. In that spirit, we offer the following comments on a few of the proposals that specifically affect emergency care.

Emergency Preparedness Requirements

CMS is proposing to alter a number of the existing requirements around emergency preparedness. In general, these changes relate to the frequency of updating a facility's emergency preparedness program and conducting training and testing sessions. As emergency physicians, we are on the front-lines 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. Overall, while we appreciate CMS' attempt to reduce burden in ways that would not affect our ability to respond to disasters, we believe that the proposed changes would move us down a slippery slope that could potentially weaken our disaster preparedness efforts going forward.

Requirements for Review of Emergency Plans and Training

ACEP does not support CMS' proposal to allow healthcare facilities participating in Medicare and/or Medicaid to review their emergency preparedness programs and conduct training exercises every two years instead of annually. If facilities were to move

WASHINGTON, DC OFFICE
2121 K Street NW, Suite 325
Washington, DC 20037-1886

202-728-0610
800-320-0610
www.acep.org

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to every two years for review and testing, they would probably substantially cut resources that currently support emergency management and preparedness. This is especially true for smaller facilities that already have limited budgets. Furthermore, staff within facilities could easily change over the course of a two-year period. Therefore, if this proposal were finalized, it would be quite possible for some staff who have been in a facility for over a year to not be properly prepared for a disaster. We have made a lot of progress responding to disasters over the last several years, but these changes, if finalized, would set us back and make it increasingly more difficult to engage in successful responses.

Requirements for Emergency Plans

ACEP does not support the proposal to eliminate the requirement that healthcare facilities document efforts to contact local, tribal, regional, State, and Federal emergency preparedness officials, and that they document their participation in collaborative and cooperative planning efforts. While CMS still would require facilities to *include* a process for cooperation and collaboration with these entities during a disaster, ACEP believes that, without the documentation requirement, facilities may not engage appropriately or adequately with all the stakeholders necessary to having a coordinated response to a disaster. They also may lose the opportunity to develop or strengthen essential community partnerships that could help them to identify and address any risks or gaps in their emergency preparedness plans.

Requirements for Testing

CMS is proposing to provide more options for providers of inpatient and outpatient services to meet their testing requirements. ACEP is concerned with the plethora of options that these providers will now have, especially outpatient providers who would be allowed to conduct the testing exercise of their choice every other year. If given the choice between a tabletop exercise and a drill, providers will almost certainly choose the tabletop exercise every time since it is less expensive. Comprehensive "boots on the ground" drills are critical to having successful responses and are more effective than tabletop exercises or workshops. CMS should reconsider providing inpatient and outpatient providers with this amount of flexibility in the final rule and continue to enforce more stringent requirements.

ACEP also seeks clarification on the proposal that if inpatient or outpatient providers experience an actual natural or man-made emergency that requires activation of their emergency plan, these providers are exempt from engaging in their "next required" community-based or individual, facility-based functional exercise following the onset of the actual event. Since the requirements for community-based or individual, facility-based functional exercises for inpatient and outpatient providers are changing, it would be helpful for CMS to provide some examples of when the next exercise would be required following the onset of an actual event. Therefore, we request that if CMS were to finalize this proposal, the agency include specific examples in the final rule.

Ambulatory Surgical Centers (ASCs)

ACEP opposes CMS' proposal to eliminate the requirements that: 1) an ambulatory surgical center (ASC) have a **written transfer agreement**; and 2) the physicians performing surgery in the ASC have **admitting privileges** with a hospital that is a local, Medicare-participating hospital or a local, nonparticipating hospital that is eligible for payment for emergency services. In providing a rationale for both these proposed changes, CMS claims that the changes would address the competition barriers that currently exist in some situations where hospitals providing outpatient surgical services refuse to sign written transfer agreements or grant admitting privileges to physicians performing surgery in an ASC. While ACEP cannot comment on the current relationships between some surgical specialists and hospitals, we do believe that, were the proposals to be finalized, this theoretical

benefit definitely would not outweigh the ultimate cost to patients who need emergency treatment, for the following reasons.

Transfer Agreement

ACEP believes that the transfer of patient care responsibilities between physicians and facilities must be orderly, clearly defined, and properly documented. Having a transfer agreement in place is a key check to make sure that both the ASC and the accepting hospital manage patient care appropriately and that the accepting hospital offers evidence-based treatments and has staff that is able to take care of all possible patient complications. Although ACEP understands that the Emergency Medical Treatment and Active Labor Act (EMTALA) requires the hospital to respond to any emergency regardless of a transfer agreement, the transfer agreement itself provides value because it holds both sides to a set of quality standards that allows the hospital to know what it can expect in terms of emergent transfers in the future. Without a transfer agreement, ASCs may also not know for certain whether there are appropriate specialists available at the accepting hospital, thereby leading to multiple transfers in some cases. This scenario could be devastating for patients, as their care would be significantly delayed. In all, the transfer agreement provides a necessary check on the quality of care that is delivered to patients and therefore must continue to be required.

Admitting Privileges

Beyond the transfer agreement, ACEP also believes that the physicians performing surgery in the ASC must continue to have admitting privileges with the hospital. This current requirement helps ensure that emergency departments (EDs) are appropriately staffed and that hospitals are able to maintain reliable on-call systems that enable the hospitals to fulfill all the obligations of EMTALA. Even now, in order to have appropriate coverage of specialty care in EDs, some hospitals have had to compensate on-call specialists for taking call, resulting in increased costs to patients and the system overall. Coverage gaps still persist in some EDs across the country. Removing the requirement that physicians performing surgery in the ASC must have admitting privileges would exacerbate this problem by incentivizing surgical specialists to drop their hospital affiliations and required call panel participation. Just like with the proposed elimination of the written transfer agreement, this proposal would potentially jeopardize patient care.

Community Mental Health Centers (CMHCs)

CMS is proposing to remove a requirement for community mental health centers (CMHCs) to update the client comprehensive assessment every 30 days for all CMHC clients and only retain the minimum 30-day assessment update for those clients who receive partial hospitalization program services. This proposal could impact emergency patients, since some EDs receive patients directly from CMHCs on mental health holds. In these cases, it is important for the treating emergency physician to know what medications, particularly psychiatric medications, the patient is taking. It is unclear whether dropping the 30-day comprehensive assessment requirement would reduce accuracy and the availability of medication lists for such patients transferred to an ED. ACEP therefore asks CMS to clarify whether it would still be possible for these CMHCs to maintain updated medication lists even if comprehensive assessment requirements are eliminated.

We appreciate the opportunity to share our comments. If you have any questions, please contact Jeffrey Davis, ACEP's Director of Regulatory Affairs at jdavis@acep.org.

Sincerely,

Vidor E. Friedman, MD, FACEP
ACEP President