August 18, 2022

Chiquita Brooks-LaSure **CMS-3419-P**
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8016
Baltimore, MD 21244-8016

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 the American College of Emergency Physicians (ACEP) and the American Academy of Family Physicians (AAFP) and the 167,600 members we serve, we appreciate the opportunity to provide feedback on the proposed rule, "Medicare and Medicaid Programs; Conditions of Participation (CoPs) for Rural Emergency Hospitals (REH) and Critical Access Hospital CoP Updates."

Emergency and family physicians currently provide emergency care in rural communities across the country and will continue to do so once the REH designation takes effect. The proposed rule recognizes that an REH that is "overseen by a highly qualified physician with a high level of expertise in emergency medicine" would benefit patients. While CMS *encourages* REHs to have a physician with emergency medicine experience serve as their medical director, CMS only proposes to require REHs have one doctor of medicine or osteopathy on the professional health care staff but does not specify when physician supervision or involvement is required.

ACEP and AAFP understand the workforce challenges that exist in rural areas. However, **to ensure quality emergency care, it is critical that a physician with training and/or experience in emergency medicine provide the care or oversee the care delivered by non-physician practitioners.** 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. 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 clinicians to meet a level of care that is safe for patients. The table below compares the training requirements between physicians, NPs, and PAs.

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/COMLEX I: 8 hours, 280 questions - USMLE/COMLEX II: 9 hours, 315 questions - USMLE/COMLEX III: 16 hours, 412 questions, 13 case simulations - Emergency medicine specialty board: 4 hours, 225 questions *or* Family medicine specialty board: 6 hours, 300 questions	3 hours, 150-200 questions	5 hours, 300 questions

The highest quality, most efficient patient care is provided by physician-led teams of health professionals. An American Medical Association survey found that more than four out of five **patients prefer a physician-led health care team.** Additionally, nine out of ten respondents said that a physician's additional years of education and training are vital to optimal patient care, especially for complex or emergency conditions. Depending on the specific health setting needs, a team-based approach can include various combinations of physicians, nurses, nurse practitioners, physician assistants, pharmacists, social workers, case managers and other health care professionals. Members of the team share information and assist in decision making based on their unique skills – all with the common goal of providing the safest, best possible care to patients. However, these teams require leadership, and physician expertise is widely recognized as integral to quality medical care. With postgraduate education and extensive clinical training, physicians are the natural leaders in the overall delivery of health care.

As such, ACEP and AAFP request that CMS modify the "Staff and Staffing Responsibilities" CoP to make it a requirement that a physician with experience in emergency medicine (either a board-certified emergency physician or a family physician with significant expertise in emergency medicine) provide the care or oversee the care delivered by non-physician practitioners. CMS should clarify that REHs must comply with existing Medicare supervision requirements, which requires direct supervision of outpatient services furnished in hospitals and critical access hospitals. Rural patients should not be subjected to a lower quality of care solely because of their location.

Thank you for your consideration of this proposed modification to the "Staff and Staffing Responsibilities" CoP. If you have any questions, please contact Meredith Yinger with the American Academy of Family Physicians, myinger@aafp.org, or Jeffrey Davis with the American College of Emergency Physicians, jdavis@acep.org.

Sincerely,

Gillian R. Schmitz, MD, FACEP
ACEP President

Sterling Ransone, Jr, MD, FAAFP
AAFP President