VIA ELECTRONIC SUBMISSION

September 15, 2021

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1753-P
P.O. Box 8010
Baltimore, MD 21244-1850

RE: Calendar Year 2022 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule (CMS-1753-P)

To whom it may concern:

The Bipartisan Policy Center (BPC) appreciates the opportunity to respond to the Request for Information (RFI) on the Rural Emergency Hospital (REH) program included in the Calendar Year 2022 (CY22) Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System proposed rule.

A non-profit organization founded in 2007 by former U.S. Senate Majority Leaders Howard Baker, Tom Daschle, Bob Dole, and George Mitchell, BPC combines the best of ideas from both parties to promote health, security, and opportunity for all Americans.

BPC staff developed the comments below to reflect expertise and input from our health care leaders and a broad range of stakeholders. They do not represent official positions of BPC's founders or board of directors.

BPC's extensive work in rural hospital transformation policy has informed our recommendations. Key recommendations for the REH program include:

- Provide REH facilities the flexibility to use new additional facility payments to offer extra medical and social support services, such as wellness and preventive care; mental health; substance abuse and opioid use disorder services; oral health services; end-stage renal disease care; and social supports, such as transportation, including for maternal care services and for food or housing assistance.

- Require rural hospitals (including new REHs) to report at minimum on a narrow set of rural-relevant quality indicators to increase accountability and advance quality of care in rural communities. When possible and appropriate, such indicators should be risk-adjusted for social determinants of health and include access to care measures (where available).

- Encourage local communities to complete a community needs assessment - with full participation from community stakeholders - to ensure transformation to new delivery models will improve access to high-quality care in the local area, and urge the secretary of HHS to assist rural communities in taking findings from such assessments to develop a hospital transformation action plan.

- Allow REHs to have a minimal number of inpatient beds (or perhaps a certain number of enhanced observation beds) in communities with little or no access to inpatient care.

- Expand REH program eligibility to allow Critical Access Hospitals (CAHs) or rural hospitals that closed within the last five years, but otherwise meet the REH criterion, to participate in the program. Also, allow establishment of REHs in rural areas that previously lacked a rural or critical access hospital, if establishment of such a facility could improve access to health care in the community.

- Evaluate the REH reimbursement structure on an ongoing basis to ensure it can support sustained transformation among rural hospitals, particularly in communities that are most at-risk of losing all hospital services if the local facility closes.

- Allow – or at minimum test – other payment pathways for eligible REH facilities as a way to increase program participation and increase access to care for rural residents. Such alternative payment pathways may include allowing REHs the option to receive enhanced outpatient prospective payment system payments plus a per member per month (PMPM) payment based on the number of anticipated patients in an expected catchment area as an alternative to relying solely on the fixed facility payment currently under consideration. The secretary may also wish to consider some form of cost-based reimbursement – akin to how Critical Access Hospitals (CAHs) are currently paid – for certain services provided at REH facilities. Finally, REHs should be provided the opportunity to participate in global payment models being tested or implemented at HHS.

- Clarify whether REHs would be eligible to receive Medicaid disproportionate share (DSH) supplemental payments and assess whether losing acess to such payments would pose a barrier for struggling rural hospitals to transform to an REH. Also, broadly evaluate the role Medicaid could play in the REH program, including whether policy changes are required to ensure access to care for Medicaid and dual-eligible beneficiaries living in rural areas.

- Evaluate the REH reimbursement rate and structure to ensure REH providers can maintain strong virtual and telehealth service capabilities.

- Allow all outpatient mental health and substance use services as eligible in the REH model, as well as any additional support services that surface during the community needs assessment.

- Make funding available to REHs from HRSA programs, such as the Title V Maternal and Child Health Block Grant program, to ensure access to maternal care services. In addition, encourage states to provide enhanced Medicaid reimbursement for maternal care services that can be provided appropriately in the outpatient REH setting.

Background on BPC's Recent Work Related to Rural Hospital Transformation and Strengthening Access to Rural Health Care Services

Prior to the COVID-19 public health crisis, rural communities across the nation were experiencing increasing hospital closures. Despite worsening health and elevated maternal and infant mortality rates, a total of 138 rural hospitals have closed since 2010.[1] During the pandemic, rural stakeholders report continued struggles to recruit and retain health care providers, and rural residents continue to travel long distances to seek care in many rural communities.[2]

Recognizing the critical need to shore up rural hospitals and strengthen access to rural health care, BPC has completed two rural health reports evaluating the rural health landscape and offering bipartisan solutions to stabilize the rural health infrastructure.

In 2018, BPC released *Reinventing Rural Health Care: A Case Study of Seven Upper Midwest States*. The report described the challenges around rural health care access and delivery and highlighted opportunities for improvement. Specifically, the report set forth recommendations around rightsizing health care services to fit community need, creating rural funding mechanisms, building the primary care workforce, and expanding telemedicine services.

Building on this work, BPC convened a Rural Health Task Force consisting of rural stakeholders, former policymakers, and experts to evaluate additional aspects of the rural health landscape and develop policy recommendations to address the potential transformation of rural hospitals and other critical rural health issues. This work culminated in the 2020 release of a report entitled *Confronting America's Rural Health Care Crisis*.

The 2020 report outlined a series of detailed policy recommendations related to ensuring the appropriate provision of rural hospital inpatient and community-based services, addressing rural workforce shortages, improving access to maternal health care, and optimizing the use of technology to increase access to care in rural communities.

More specifically, the 2020 report included detailed policy recommendations for addressing rural hospital closures, and it offered pathways for rural hospital transformation. Many of the report's recommendations remain relevant to the development of new rural emergency hospital models and could serve as guideposts for the establishment of the new REH program. Given the urgent need for transformation among rural hospitals and the ready availability of data-driven benchmarks and milestones to guide such change, BPC would urge the secretary to consider the below comments.

Considerations for the Establishment of the Rural Emergency Hospital (REH) Program

The RFI outlines a series of questions related to the establishment of rural emergency hospitals, including requested input on the role of virtual care, maternal care, behavioral health services, and other important items. BPC will provide comments related to these questions below. However, BPC would also like to submit general feedback related to the broader rules, eligibility criteria and payment structure governing the REH program.

As referenced above, BPC outlined specific policy recommendations related to establishing a rural emergency hospital model in its 2020 report. The Rural Emergency Hospital program, as enacted by Congress in the Consolidated Appropriation Act of 2021 (CCA, P.L. 116-260), contains many foundational elements that are in-line with BPC's recommendations.

Most importantly, the REH program will offer rural communities a new, viable health care delivery option that holds promise for stabilizing, maintaining, and expanding access to critical hospital services in rural communities. Similar to BPC's recommendations, the REH program will be available beginning in 2023, which ensures rural communities have access to a new payment model in the near future.

In addition, the REH program includes two other critical components that are in-line with BPC's recommendations: allowing REHs to offer additional services and subjecting rural hospitals to quality measurement reporting requirements. Together, these elements will provide REHs the necessary tools to meet local health needs as well as ensure REHs are a source of high-quality care in local communities.

Allowing Flexible Use of Additional Facility Payments

During the development of the BPC report, rural stakeholders strongly emphasized the importance of allowing rural hospitals to better tailor care to their local community need, rather than requiring a one-size-fits-all approach. In light of this finding, the new program will allow REHs to offer additional medical, health care, and possibly social support services, beyond traditional outpatient and emergency care, as specified by the secretary. Such additional services would be reimbursed through an additional facility payment, as set forth in the statute.

Stakeholders specifically recommended that rural emergency hospitals be allowed to use flexible, facility payments to provide additional critical services to their communities. BPC agreed with this input and continues to recommend allowing rural emergency hospitals to use additional payments to cover a range of services, such as wellness and preventive care, mental health, substance abuse and opioid use disorder services, oral health services, and end-stage renal disease care. Stakeholders also suggested funds be used to offer social supports, such as transportation, including for maternal care services, and for food or housing assistance. **BPC would urge the secretary to allow REH facilities the flexibility to use the additional facility payment to offer the extra medical and social support services described herein.**

Furthermore, as was referenced in the background section of the RFI, one in five rural residents identifies as Black, Hispanic, American Indian/Alaska Native, Asian American/Pacific Islander, or a combination of ethnic backgrounds.[3] Allowing REHs to offer a flexible range of health care and social support services will strengthen access to care for all rural residents, including minority populations, who often experience poorer health outcomes.[4]

Ensuring Quality Rural Hospital Care

In addition to offering additional services and payment options, the BPC report also recommended that rural hospitals be subject to quality measurement reporting requirements and we support inclusion of such requirements in the REH program. **Specifically, we urge the secretary to begin requiring rural hospitals (including new REHs) to report on – at minimum – a narrow set of rural-relevant quality measures to increase accountability and advance quality of care in rural communities.** In doing so, we would urge the secretary to evaluate and differentiate which measures are uniquely appropriate to apply in an REH setting relative to other hospital sites. Such measures should be risk-adjusted for social determinants of health, where possible and appropriate, and include access to care measures, where available. In addition, rural measures should be aligned across Medicare, Medicaid, and other payers to minimize reporting burden on rural facilities. The secretary also should assess on an ongoing basis whether topped out measures, such as measures that are no longer useful for larger or urban providers to report because they are successful on the metric and there is little room left for gain, should remain in the system for purposes of rural reporting. Finally, reporting of such measures should be done in a way that is not administratively burdensome to REHs or other rural providers and the secretary should provide technical assistance to support rural providers in establishing quality measurement tracking and reporting systems.

Other Important Considerations

While BPC applauds the above components of the REH program, we would also request the secretary or Congress consider the following issues or modifications.

Encouraging Communities to Assess Local Health Care Needs

First, a cornerstone of the BPC recommendations focused on encouraging rural communities to embark on a community needs assessment - with full participation from community stakeholders - to evaluate local health care needs, including gaps in health care access or services, and develop an action plan to address such needs. **BPC urges the secretary to encourage local communities to complete such an assessment to ensure transformation to new delivery models, such as the REH, will improve access to high-quality care in the local area**. This assessment could be submitted as part of the application and transition plan that facilities are required to submit in order to enroll in the REH program.

An effective community needs assessment would provide valuable information that rural communities could use not only as they consider transforming a local hospital to an REH, but also to more broadly inform efforts to improve or maintain access to local health care services, strengthen the quality of care or better coordinate care across the local or regional health care delivery system. Such assessment would also serve as an important tool for longer-range planning, including informing community health care leaders and policymakers on the financial and human resources needed to stabilize or strengthen the local health system into the future. Finally, in communities that are experiencing attrition among the health care workforce or difficulty attracting new health care providers, such assessment and plan may send a strong signal about the local communities' commitment to shoring up the health system.

Recognizing that some communities may need to transform to an REH quickly to avoid a local hospital closure and maintain access to critical services, it would still be of a value to complete such a community needs assessment in tandem with this transformation or even after an REH is established in a given community. Such assessment may be particularly useful as rural communities exit the COVID-19 pandemic and need to assess capabilities and address projected community needs going into the future.

Where possible, BPC would further urge the secretary to assist rural communities in taking findings from community needs assessments to develop a hospital transformation action plan. Such a plan would serve as an important tool to determine which health care delivery models would improve health and increase access to care for residents in the community and potentially the larger region into the future.

Finally, to support development of a community needs assessment and action plan, BPC would encourage the secretary to provide technical assistance funding and support to rural communities through Health Resources and Services Administration (HRSA) grants or Medicare revenues, as appropriate.

Ensuring Continued Access to Inpatient Hospital Care

Second, the REH program does not allow for the provision of any inpatient hospital services (other than post-hospital extended case services furnished in a distinct part unit licensed as a skilled nursing facility). Rural stakeholders and the Rural Task Force that worked together to develop BPC's recommendations vigorously debated whether to allow rural emergency hospitals to offer any level of inpatient care. Ultimately, the BPC Rural Task Force recommended that rural emergency hospitals be allowed to offer limited, acute inpatient care – with a 10 bed maximum – if a community needs assessment determined that such services were necessary to ensure adequate access to care and if such services were not available within a certain geographic distance, such as 35 miles. Although the REH program was established to provide a new health care delivery model for facilities that can no longer afford to maintain an inpatient census, **BPC continues to recommend the secretary**

or Congress consider allowing REHs to have a minimal number of inpatient beds – or perhaps a certain number of enhanced observation beds – in situations where a community would otherwise have little or no access to inpatient care. Such flexibility would ensure that rural communities maintain some level of inpatient care, particularly in cases where a community needs assessment demonstrates ongoing access to this care is critical to meet the health care needs of local residents.

Allowing Communities to Maximize Local Infrastructure

Third, in order to transform to an REH, the CCA legislation requires an applying facility either be designated as a Critical Access Hospital (CAH) or be designated as a rural subsection (d) hospital with not more than 50 beds, as of the date of enactment of the CCA legislation (December 27, 2020). **BPC recommends that eligibility be expanded to allow CAHs or rural hospitals that meet this criterion, but closed within the last five years, also be eligible for REH participation.** Allowing rural facilities that recently closed – where the physical and perhaps staffing infrastructure may still exist in the community – is a wise use of resources that could allow rural communities to transform a closed building into a new REH facility. This may allow rural communities to avoid allocating scarce resources to construct a brand new facility and may make it easier to recruit health care staff who may still reside near the previous hospital.

In addition, the secretary may also wish to consider allowing the establishment of REHs in rural communities that currently lack a rural or critical access hospital, particularly in cases where a community needs assessment demonstrates that establishment of such a facility could improve acess to health care.

Providing Sustainable Reimbursement for Rural Emergency Hospitals

Perhaps most importantly, BPC would like to comment on the payment or reimbursement structure for REH facilities. In the REH program, eligible facilities will be reimbursed an amount equivalent to the Medicare outpatient prospective payment system (OPPS) rate plus an additional 5 percent increase ("an enhanced OPPS payment") for applicable REH services. This payment would be separate from the flexible, additional facility payment (a "fixed payment") referenced above.

Allowing REHs to receive an OPPS payment that is increased by a set percent in addition to an additional flexible payment is in-line with BPC's recommendations related to an appropriate payment structure for rural emergency hospitals. However, **there is a general question regarding whether the 5% add-on to the outpatient payment is an adequate amount of funding to provide ongoing financial stability for facilities that transform to the REH model. BPC urges the secretary to continue evaluating the REH reimbursement rate and structure to ensure it is set at an appropriate level to support rural hospital transformation, particularly in communities that are most at-risk of losing all hospital services if the local facility closes.**

At the same time, BPC urges the secretary to consider allowing – or at minimum testing – other payment pathways for eligible REH facilities. Throughout the course of BPC's rural projects, stakeholders consistently suggested that for rural hospital transformation to succeed, rural communities and rural facilities must be offered flexible and varying payment options and reimbursement structures.

As another payment pathway, BPC specifically recommends the secretary consider offering REHs the option to receive the enhanced OPPS plus a per patient per month (PMPM) payment based on the

number of anticipated patients in an expected catchment area. This is another version of a fixed payment; however, the payment would be more closely tied to the number of patients projected to be treated by a given REH in a future year. In addition, the secretary may wish to consider whether a cost-based reimbursement option – akin to how Critical Access Hospitals (CAHs) are currently paid – would be an appropriate payment option for REHs or appropriate for certain services provided at REH facilities.

In addition, BPC would encourage the secretary to continue testing global payment models that combine funding from all federal payers. As such global payment models are tested or permanently established, REH facilities – either solo or in partnership with other rural facilities in their community or state – should be allowed to participate in such models and take advantage of whatever payment structure and care flexibilities are set forth.

The BPC also urges the secretary to consider offering REHs additional incentives to provide services that are deemed particularly at-risk in a given community, such as obstetric, maternal and pre-natal care, including via remote patient monitoring, as appropriate.

Evaluating the Role of Medicaid

Finally, **BPC urges the secretary to also evaluate the role Medicaid may play in the REH program**. Nearly a quarter of individuals under age 65 who live in rural areas are covered by Medicaid, as well as 22 percent of people who are dually eligible for Medicare and Medicaid.[5,6] For these residents, rural hospitals are an important source of health care services. To this end, many states have established targeted payment policies for critical access and rural hospitals, including Medicaid supplemental payments.

One of the most prevalent types of supplemental payments is the Medicaid disproportionate share (DSH) payment. DSH payments support uncompensated care costs for hospitals serving Medicaid and uninsured patients. According to the Medicaid and CHIP Payment and Access Commission (MACPAC), Medicaid DSH payments to critical access hospitals totalled $370 million in 2016.[7] Under current law, CAHs must have a Medicaid inpatient utilization rate of at least 1% in order to qualify to receive DSH payments.[8] As hospitals transform to the REH model, **BPC urges the secretary to clarify whether REHs would be eligible to receive Medicaid DSH payments** given that the REH model does not allow for the provision of inpatient care and to assess whether losing access to such payments would pose a barrier for rural hospitals that are considering transforming to an REH structure. Further, **BPC urges the secretary to broadly evaluate the role Medicaid could play in the REH program, including whether policy changes are required to ensure access to care for Medicaid and dual-eligible beneficiaries living in rural areas.**

Additional Considerations as Outlined in the Request for Information

In addition to the considerations outlined above, BPC would also like to comment on the appropriate provision of virtual care, behavioral health care, and maternal care, within the REH model.

Virtual Care

As CMS weighs the conditions of participation for REH providers, **BPC urges the secretary to evaluate the REH reimbursement rate and structure to ensure it is set at an appropriate level for REH providers to maintain strong virtual and telehealth service capabilities**. As workforce models change, rural health professionals should be equipped with the tools necessary to provide quality care to patients.

Higher mortality rates have been documented for patients with similar conditions who present to rural or remote emergency departments compared to those in urban settings.[9] In part, these disparities exist because rural hospitals have difficulty attracting and retaining providers to adequately staff facilities and they lack specialist support needed to triage, stabilize, and treat higher acuity patients.

Telehealth access can help bridge these gaps and improve health care delivery in rural areas. Using two-way interactive technology, REHs have the potential to deliver similar quality care as physician staffed services.[10] Telehealth capabilities are especially important when a time-sensitive emergency demands urgent management and intervention in order to minimize adverse patient outcomes. Tele-stroke care (i.e. telemedicine for acute stroke care) is shown to improve care quality and patient outcomes with the greatest benefits for patients in lower-volume hospitals, among rural residents, and for patients 85 years and older.[11]

Telehealth improves collaboration through telephone or videoconferencing consultations between referring hospitals and receiving hospitals, which may reduce the need for secondary triage and optimize patient management within community hospitals. For critical patients, telehealth has reduced morbidity and mortality rates, hospital admission time, and the cost of patient care.[12,13]

Telehealth can also be an important tool for REHs in the provision of non-critical emergency care. The most common hub-and-spoke type models have been found to be effective in the remote diagnosis and management of patients. For example, the hub-and-spoke telemedicine and distance-learning model Project ECHO is shown to improve patient care in rural areas. Providing remote diagnosis and disease management assistance can minimize the need for unnecessary patient transfers and allow REHs to manage more patients locally.[14]

Because financing telemedicine in low-volume hospitals can be challenging given the up-front costs for equipment and ongoing costs for internet connectivity and maintenance, **BPC urges the secretary to evaluate the cash flow needed to invest in telemedicine capabilities for REHs and if the current financing proposed is sufficient.**

Finally, BPC applauds the inclusion of REHs as originating sites starting January 1, 2023 in the CY 2022 Medicare Physician Fee Schedule Proposed Rule. It is important for REH providers to act as originating site providers for telehealth services in rural areas. While Congress, CMS, and states have adopted a multitude of temporary flexibilities to increase access to telehealth services during the COVID-19 Public Health Emergency, REH providers will continue to be an important access point for individuals experiencing technology barriers. There are existing and persistent barriers to broadband availability, technological devices needed to conduct a video visit, and digital literacy in rural areas.

BPC recently partnered with Social Sciences Research Solutions (SSRS) on a consumer survey that shows forty-five percent of adults experience some type of technology or access barrier to participate in telehealth services. These barriers are much more pronounced for the elderly and those living in rural areas.

Behavioral Health

The RFI also seeks input on the additional outpatient medical and health services, including behavioral health services, the secretary should consider as additional eligible services appropriate in rural emergency hospitals.

The secretary should consider all outpatient mental health and substance use services as eligible in the REH model and any additional services that are surfaced from the hospital's community needs assessment.

Adequate access to behavioral health professionals, especially in rural areas, is an ongoing barrier to necessary patient care. A community needs assessment would allow communities to identify services that beneficiaries may otherwise have a lack of access to if an REH does not provide them. For example, some communities may need mobile crisis services or an opioid treatment program. In such instances, the REHs should have the option to include these services as part of their scope and CMS should evaluate if current REH financing mechanisms ensure the reimbursement is adequate to provide such services.

Addressing Gaps in Maternal Care Services

The RFI also seeks input on the appropriate role of maternal care in rural emergency hospitals as well as unique challenges of providing such care in rural communities.

The issue of maternal care and addressing maternal mortality and morbidity has been a key focus of policymakers in recent years. According to the World Health Organization, the United States continues to have a higher rate of maternal mortality than other industrialized nations.[15] The cause of this is multifactorial, but evidence shows that a recent loss of obstetric services diretly correlates with poor clinical outcomes and increased infant and maternal mortality.[16] For rural communities, this is a significant problem. In recent years, rural hospitals have continued to close obstetric units, leaving fewer than half of rural counties with access to such hospital-based obstetric care.[17] Decreasing access to obstetric units can make it increasingly difficult for rural residents to access needed maternal care services. One study surveyed 306 rural hospitals across nine states and found that women can travel up to 65 miles to receive prenatal care after their local obstretic unit closes.[18]

Against this backdrop, the outpatient and emergency care nature of rural emergency hospitals will by definition not likely be equipped to offer robust maternal care services. However, **BPC would recommend that REHs be encouraged to determine what role these new facilities can play in offering outpatient pre- and post-natal services, including primary care-based services to pregnant women, new moms and their babies**.

To ensure access to maternal care services, BPC recommends that the secretary make funding available to REHs from HRSA programs, such as the Title V Maternal and Child Health Block Grant program. Such funding could be targeted toward providing critical obstetric training for health care providers who are not obstetricians, but could be a source of primary care maternal care services in rural communities. These primary care-based services could include prenatal care, diagnostics and training on appropriate referral guidelines for maternal care, including high-risk maternal services.

In addition to addressing maternal care provider shortages, additional funding is required to cover the cost of providing maternal care services. In most communities, Medicaid is the dominant payer for maternal care, covering 50-60% of all births in the rural U.S.[19]. However, the National Rural Health Association estimates that Medicaid reimbursement for obstetric services is approximately one-half the rate of commercial insurance and falls short of covering costs.[20]

As CMS implements the REH program, BPC recommends that the secretary provide incentives to states to offer higher Medicaid reimbursement for maternal care services

that can be appropriately provided in the outpatient REH setting. Such higher reimbursement, which could include increased federal matching payments to states, would help close the current Medicaid funding gap and provide REHs needed resources to offer maternal care services in their community. In addition, the secretary should require REHs to provide pregnant women and new moms information on where maternal care services can be obtained within the broader community, if such services are not otherwise available at the REH.

Next Steps

BPC appreciates the opportunity to comment on the implementation of the Rural Emergency Hospital program. BPC will continue to work with stakeholders to evaluate the impact of the REH model's implementation in rural communities, including the degree to which the new program impacts access to needed health care services. To that end, BPC has teamed with a number of midwestern states to assess the rural health landscape, including perspectives on the REH program and the overall financial health of rural facilities during the COVID-19 pandemic.

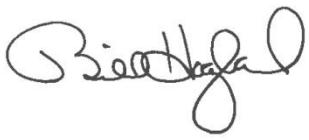
While our work regarding the pandemic remains ongoing, rural stakeholders in a number of states have indicated that the pandemic has had a dual impact on rural facilities. First, and similar to their urban counterparts, rural hospitals struggled with bed and staffing capacity concerns as the need for inpatient care increased during the pandemic. At the same time, federal financial relief provided to rural hospitals, primarily through the CARES Act (P.L. 116-136), provided financial stability to many struggling rural hospitals and likely resulted in fewer hospitals closing than would have otherwise occurred absent the extra federal resources.[21] Unfortunately, preliminary feedback suggests that the same rural hospitals that were struggling financially before the pandemic will once again be at risk of closure as federal relief funds dwindle.

Against this backdrop, BPC is continuing to explore and develop additional recommendations to shore up and strengthen access to care in rural communities. We look forward to sharing these recommendations with the secretary and appreciate the opportunity to work with policymakers on this critical effort.

Closing

Thank you for the opportunity to submit comments related to the Rural Emergency Hospital program and considerations around ensuring access to care in rural communities. Please do not hesistate to contact us if you have questions or if we can provide additional information.

Sincerely,



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Endnotes

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