Testimony before the Ways and Means Committee

Access to Health Care in America: Ensuring Resilient Emergency Medical Care

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Chairman Smith, Ranking Member Neal and Ways & Means Committee Members, thank you for the opportunity to be with you today. My name is Rob Morris, and I live just down the road in the town of Southlake. I am CEO of Complete Care, a company with 15 freestanding emergency centers (FECs) in Texas and Colorado. I am also the president of the National Association of Freestanding Emergency Centers, which represents FECs and specialty emergency hospitals across the country. I would like to start by welcoming you to Texas -- the state that pioneered a new and innovative model to improve access to emergency care.

Recognizing our emergency rooms were overcrowded, patients were at risk because of dangerously long ER wait times, and rural areas were lacking healthcare infrastructure, over a decade ago Texas created a pathway for licensure for FECs that could function independently of a hospital. Before helping found our company in 2012, I spent the majority of my career working with hospitals. I have served in various leadership capacities, including a background managing the emergency department, so I have experience working in both freestanding and hospital-based settings.

Our company, like many other FEC operators, includes physicians, nurses, and other healthcare staff who typically left their hospital-based positions to work in an environment with more flexibility, autonomy, and time to dedicate at the bedside. Through the years, FECs have helped to decongest overcrowded hospital ERs, increase competition, and streamline patient care. Over 200 FECs now operate in several states such Texas, Colorado, Delaware, and Rhode Island. The vast majority are located in Texas.

Background on Freestanding Emergency Centers

FECs are highly regulated state-licensed facilities that provide 24/7 emergency services to patients at the same level of care as hospital-based emergency rooms, with experienced ER doctors, nurses, and radiology technologists always on site. Our facilities provide advanced imaging, laboratory, and pharmacy services. FECs diagnose, treat, and stabilize all major medical emergencies, including heart attacks, strokes, fractures, lacerations, and trauma. We comply with federal and state EMTALA requirements, which require screening and stabilization of all patients regardless of ability to pay. We comply with the No Surprises Act and believe patients should be protected from unexpected medical bills by limiting patient financial responsibility to in-network cost-sharing amounts.

Our facilities have transfer agreements in place and work cooperatively with our hospital partners when a patient requires surgery or an inpatient stay. The transition from the ER to surgical or inpatient care can be timelier when originating from our facilities. FECs have the ability to coordinate transfers to hospitals with available capacity, whereas hospital-based ERs

typically only admit patients to their own institution.

Since the inception of our emergency care delivery model, we have learned the importance of self-policing. Although there will always be a small minority of "bad actors" in various segments of healthcare, the vast majority of FEC operators work in this space for the right reason: To provide exceptional emergency care to patients. We believe if we focus on one thing and one thing only, we can deliver exceptional services. The market has self-corrected and the few FEC operators who were in it for the wrong reason went out of business due to their own self-inflicted wounds. Our state and national associations recognize the importance of holding our Members to a high standard, and we have successfully advocated for additional policies that protect our patients. For example, Texas now has strict rules in place regarding caps on facility charges, disclosure requirements to help minimize confusion regarding ER versus Urgent Care, and guardrails that nearly eliminate the chance of patients receiving surprise medical bills. Patients are better protected because of our collective efforts and the lessons we learned early in the life cycle of our industry. As additional states adopt the FEC model, much of the heavy lifting surrounding patient protections has already been done.

An Answer to Rural Health Care Access Issues

Mr. Chairman, you understand the challenge rural communities confront in accessing health care. Since 2010, 156 rural hospitals have closed, with another 15 rural hospitals closing last year. This is more than double the amount from 2022.[1] These hospital closures contribute to poor patient outcomes and exacerbate access to care issues in rural areas, especially emergency care, forcing patients to drive long distances to receive emergency treatment. Proximity to emergency care can mean the difference between life and death.

The situation could deteriorate further if policy changes to our health care system are not made. A recent report from the Center for Healthcare Quality & Payment Reform found that more than 600 rural hospitals, which represents 30 percent of all rural hospitals, are at risk of closing.[2] More rural hospital closures put 60 million Americans living in rural areas at risk of having limited or no real access to emergency services.[3]

FECs are eager to be a solution for the rural health care crisis. However, a key impediment to FECs expanding to rural areas is the current inability of this relatively new delivery model to qualify for Medicare and Medicaid reimbursement. According to the American Hospital Association, Medicare and Medicaid comprise 56 percent of rural hospitals' net revenue.[4] Because rural areas tend to have higher concentrations of Medicare and Medicaid beneficiaries, building FECs in these areas is unviable.

The lack of Medicare recognition for FECs reflects the unfortunate reality that the Medicare statute lags behind innovative delivery models and must be updated.

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[1] Rural Hospital Closures. Cecil G. Sheps Center for Health Services Research. The University of North Carolina

[2] Rural Hospitals at Risk of Closing, Center for Healthcare Quality & Payment Reform.

[3] One in Five Americans Live in Rural Areas. United States Census Bureau. April 09, 2017.

[4] American Hospital Association. 2019 Rural Report.

FECs are particularly well-positioned to provide care in rural areas when Medicare and Medicaid reimbursement becomes available. States have the ability to encourage FEC growth in rural areas when developing their licensure requirements. For example, Mississippi has a pilot program that allows freestanding emergency rooms to be built in counties without emergency hospital care. However, success in these underserved areas first requires Medicare and Medicaid recognition.

Unlike a hospital, FECs are efficient sites of care that do not carry the substantial fixed costs of building and staffing numerous, often vacant, operating rooms and inpatient beds. Nor do they need to spend resources on trying to recruit and maintain physician specialists (other than ER physicians) in remote areas where these physicians tend not to reside. Because FECs are efficient and can maintain lower overhead costs, they have a greater ability to serve areas that may be unattractive or unviable for hospitals.

Congress recognized the importance of maintaining access to emergency care in rural areas when it authorized Rural Emergency Hospitals (REHs) several years ago, which allows economically failing critical access hospitals to convert into an REHs. This is essentially an FEC that receives enhanced reimbursement rates. However, the law does not permit an FEC that was not first a hospital to obtain Medicare and Medicaid recognition. With the overhead requirements, staffing issues, and other financial constraints incurred with operating a full-blown hospital in a rural community, it would seem reasonable to allow FECs to be recognized in the first place. The REH designation was created to prevent the loss of essential emergency care. FECs offer the ability to provide that same level of emergency care and also avoid unnecessary hospital closures.

Temporary Medicare Coverage Under Waiver Showed Efficiency of FECs

Thanks to Rep. Jodey Arrington and other congressional leaders, in April 2020 FECs secured a Centers for Medicare and Medicaid Services (CMS) waiver that allowed them to enroll as Medicare-certified hospitals and receive Medicare reimbursement for the duration of the COVID-19 public health emergency (PHE).[5] Over 125 FECs enrolled and were able to provide high-quality emergency services to tens of thousands of beneficiaries for all kinds of emergency conditions at a significant savings to the Medicare program. FECs effectively stepped up to help alleviate nearby hospitals that were overwhelmed with COVID-19 patients and provided care for patients in their local communities closer to home.

An actuarial analysis from Dobson-Davanzo that examined the Medicare claims data from 2019 to 2022 found that on a severity level standardized basis, Medicare saved more than 21 percent for emergency care provided in FECs compared to hospital ERs. Additionally, the analysis found that there was no overall increase in ER services in Texas, where the FECs that participated in Medicare were located, compared to the rest of the country.[6] Texas ER utilization remained statistically consistent with ER utilization across the United States after FECs gained temporary Medicare recognition. There was simply a market share shift of patients from hospitals to FECs.

[5] Center for Medicaid & Medicare Services (2020). Guidance for Licensed Independent Freestanding Emergency Departments (EDs) to Participate in Medicare and Medicaid During the COVID-19 Public Health Emergency.

[6] Dobson-Davanzo & Associates. "Effect of the Medicare Waiver for Freestanding Emergency Centers on Emergency Service Utilization." October 12, 2023.

This comprehensive analysis of the claims data demonstrates that competition works to contain costs and outdated narratives of increased patient choice results in overutilization are unfounded when it comes to FECs participation in the Medicare program.

These savings do not capture the substantially reduced inpatient admissions that FECs achieved, thus saving Medicare and our taxpayers even more money. FECs have no incentive to fill empty hospital beds. The study found that FECs were over twice as likely to discharge Medicare beneficiaries home compared to hospital ERs.

When considering patient acuity, FECs treated a wide variety of emergent conditions and traumatic injuries. Distribution of ER encounters by severity showed 86.1% FECs cases were mid-high level of severity, while 90.5% of hospital ER cases were mid-high level of severity.

This empirical analysis of the Medicare claims file demonstrates that FECs increase access to emergency care without increasing Medicare costs AND save the Medicare program significant resources by providing more efficient care. By imbedding FECs in the community, patients are able to receive more timely treatment. We believe this is due to our nimble, patient-centered model, where patients are seen within minutes of arrival and receive focused, individualized care. Due to being seen quicker and earlier in their disease process, patients have better outcomes, require less medical care, and are less likely to be admitted to the hospital for preventable reasons.

Additionally, unlike a hospital ER where medical and ancillary staff are frequently required to support functions in other departments of the hospital, our team is strictly focused on providing services to patients within the confines of the FEC. When a patient arrives at an FEC, all human resources are dedicated to delivering an exceptional experience. Because our physicians have more time to spend at the bedside, they are able to more effectively evaluate the patient's condition and only order diagnostic tests, such as labs and radiology, that are absolutely necessary.

Due to the rushed, overcrowded conditions frequently found in a hospital ER, it is common for diagnostic tests to be ordered before the physician lays eyes on the patient. Tests are ordered based on the patient's presenting condition, so results are frequently available prior to the physician examining the patient. This is an understandable approach due to the hectic nature of a hospital ER, where the lobby and exam rooms are often full and patients who have been waiting hours. This approach expedites care by allowing diagnostic testing results to be in hand when the physician physically evaluates the patient. However, when tests are ordered before the physician has spent time with the patient, a "wide net" is frequently cast and unnecessary tests are performed. In an FEC, however, almost all diagnostic testing and treatment is done AFTER the physician has physically evaluated the patients. Fewer diagnostic tests are performed on patients, with the same level of acuity, when compared to a hospital-based ER. This results in lower costs, as evident in the Medicare claims data.

Simply put: FECs are able to focus on doing one thing exceptionally well. This level of focus leads to better patient satisfaction, improved clinical quality, and lower costs. Unfortunately, the temporary waiver that allowed FECs to be certified Medicare providers expired last year when the PHE ended. Congressional action is now needed to reinstate that coverage.

Emergency Care Improvement Act is a Solution to Health Costs

The Emergency Care Improvement Act (H.R. 1694) modernizes the Medicare statute, improves patient access, and encourages competition by providing statutory Medicare recognition for FECs. The bill has been endorsed by the American College of Emergency Physicians, the thought leader on emergency care. As mentioned, the Dobson Davanzo analysis of more than two years of PHE utilization data shows that FECs can deliver more than 21 percent savings without any increase in ER utilization. CBO should be encouraged to perform an analysis based on data from the real-life Medicare demonstration project that occurred under the waiver and avoid theoretical narratives that imply greater competition increases costs.

The bill includes a notable provision that addresses the issue of low-acuity patients inappropriately utilizing emergency rooms. While the comprehensive Dobson Davanzo analysis found that low acuity patients (i.e., levels 1 and 2) make up a small percentage of FEC encounters, some patients may be more appropriate for an urgent or primary care clinic. In addition to state laws requiring signage and disclosures clearly informing patients of our ER status, the bill also explicitly prohibits facility reimbursement for these low-acuity patients. Since FECs would not bill these patients for anything other than the professional fee, this policy also establishes a useful precedent for reforming hospital payment for low-acuity patients.

Finally, the bill would not permit Medicare recognition of a new FEC located in a rural county already served by any type of hospital, as we have no interest in threatening or competing with struggling rural hospitals.

Expiration of Waiver and NSA Implementation Put FECs in Financial Duress

As our Medicare revenue dropped to zero, the No Surprises Act implementation has dramatically cut commercial reimbursement and threatened patient access to care. Some FEC companies have successfully achieved network status with major health plans. Many others have been unsuccessful and gone out of business. It appears some insurers may be inappropriately weighting qualified payment amounts (QPAs), which result in artificially low QPAs. These initial QPAs offered by the insurers are often below the Medicare rate, which was explicitly abandoned by Congress in the development of the statute for being too low and unreflective of commercial market rates. This tactic attempts to drive down QPA rates to use them as a "historical" reference benchmark during arbitration while simultaneously forcing more providers out of network. Many FEC companies have struggled to be accepted as in-network providers by certain health plans in the first place, as the plans prefer to rely on the independent dispute resolution (IDR) process, which puts even more financial duress and responsibility on providers.

The $115 administrative fee associated with the IDR process, as well as the inflated fees for the certified independent dispute resolution entities that range between $375 to $1,170, are also financially devastating to providers. It's not unreasonable to consider that claims are significantly underpaid by health plans knowing the only action for providers is the NSA dispute process. Dispute fees have significantly less of an impact on insurers who have the ability to increase premiums or cost share to generate more revenue. It is also well known that insurers have significant IT and programming infrastructure that has allowed them to efficiently prepare

automated dispute response packages whereas providers, with limited resources, rely on the manual preparation of each and every dispute package. Providers are struggling to stay afloat, yet insurers do not appear to be experiencing the same financial demise. As a direct result, we have seen and will continue to see (without change) an increase in providers closing facilities.

As you know, the provider community has prevailed in litigation in all four of the Texas Medical Association cases brought against CMS for the failed implementation process and substantive violations of the statute, which was carefully crafted by Congress. We are grateful the Ways and Means Committee has led Congress in providing needed oversight on the botched implementation of the NSA.

Conclusion

On behalf of the National Association of Freestanding Emergency Centers, thank you for organizing this field hearing and learning about a model that will improve access to emergency care, particularly in rural communities. We look forward to working with the committee and Congress on improving patient access to high quality emergency care by providing permanent Medicare recognition to FECs and properly implementing the No Surprises Act.