The Honorable Jason Smith
Chairman, House Committee on Ways and Means
1139 Longworth House Office Building
Washington, D.C. 20515

*Submitted via email at WMAccessRFI@mail.house.gov*

October 5, 2023

**Re: Request for Information "Improving Access to Health Care in Rural and Underserved Areas"**

Dear Chairman Smith:

Thank you for the opportunity to provide feedback on your Request for Information (RFI) entitled "Improving Access to Health Care in Rural and Underserved Areas." The Emergency Department Practice Management Association (EDPMA) is the nation's only professional trade association focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups of all sizes, billing, coding, and other professional support organizations that assist healthcare clinicians in our nation's emergency departments. Together, EDPMA members see or support 60% of all annual emergency department visits in the country. Many of our members serve patients in rural areas, so we hope to offer a valuable perspective when it comes to emergency care in remote settings.

Rural populations often experience disproportionate challenges with social determinants of health:

Basic individual needs:

- **Access to food**: food deserts; no delivery services for the homebound
- **Geographic isolation**: long distance to access services; limited services available locally
- **Transportation challenges**: lack of reliable transportation, lack of public transportation or taxis; overburdened emergency medical services (EMS)

Community needs:

- **Limited housing options**, including options with accessibility for wheelchair or other mobility needs
- Large utility grids with little redundancy

Additional challenges:

- **Broadband Access**: Internet/Wi-Fi dead zones; poorly performing connections limiting virtual care options
- **Agricultural work** (both patients and caregivers): in-person medical appointments can be challenging

A well-functioning emergency care system in any setting requires three basic pillars: (1) access, (2) delivery, and (3) transitional care. In rural settings, existing laws, regulations, and processes help support equitable access and care delivery: the Emergency Medical Treatment and Labor Act (EMTALA), the Prudent Layperson Standard, and public reporting support access to emergency care; established care standards, quality measures, and certification requirements support delivery of care; and screening for social determinants of health, care coordination, and after-care planning support transitional care for patients. Below, we provide information about specific payment models that can help build on these existing structures and maximize equitable care delivery for our rural populations.

***Geographic Payment Differences:*** *The Committee is requesting comments on policies to improve existing payment methodologies to end the perpetuation of historical payment inequities and to reduce opportunities for abuse. This includes a review of the area wage index and the geographic practice cost index. Comments should address proposals that ensure adequate payments to health care facilities while avoiding harmful cliffs and perverse incentives. Feedback is also requested on how best to ensure adequate payments to providers without creating unjustified disparities.*

Across health care, the actual delivery models in rural settings may differ from other settings. This is particularly true with emergency medicine. In many communities, emergency physicians serve a uniquely outpatient role in the emergency department and outpatient clinic settings. However, emergency physicians may also have inpatient duties, and this hybrid model is more prevalent in rural settings. Physicians who serve dual roles should not have to pick one or the other, and communities should have the opportunity to benefit from clinicians who have the skills, aptitudes, and capabilities to provide both inpatient and outpatient care. Although Medicare has an interest in preventing "double-dipping" in terms of billing for services, there should also be no incentive to have two physicians bill for two separate services, when there is one physician who can do both, particularly when that hybrid delivery can increase efficiency, enhance access to care, and provide overall cost-efficiencies. In remote locations, it is not merely a matter of efficiency to have one physician provide a variety of services; it is essential. The same physician must be in clinic and also be on call, and that physician, dedicating the time and accepting the risk of performing multiple services, should be reimbursed accordingly.

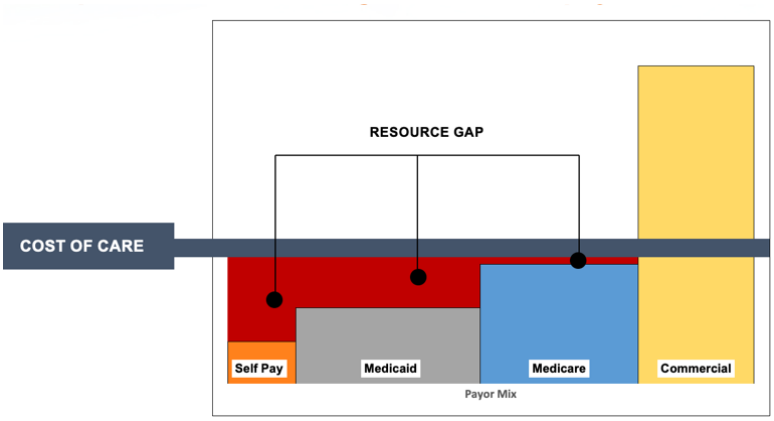
As for payment methodologies, the geographic practice cost index (GPCI) and the area wage index (AWI) are key, but as a general matter, emergency departments often have an adverse payer mix. The National Center for Health Statistics (NCHS) reports that, across all settings, 37% of all emergency department visits provide care for Medicaid and CHIP enrollees and at least 6.7% of all ED visits are provided to patients with no insurance coverage at all.[1] However, in addition to the patients who are known to be uninsured, NCHS identifies another 9.5% of patients as having "unknown" health insurance status, while another 4.2% have "other" as their insurance status. These two groups – a combined 13.7% of all patients – usually contain considerable numbers of uninsured patients as well, so the total percentage of uninsured may range anywhere from a conservative 6.7% to a staggering 20.4%. The latter number is aligned with EDPMA's members' real-world experience, which has found that the number of uninsured patients ranges from 15% to 30%, with the higher end of the range most often occurring in rural areas.

EMTALA's guarantee that every emergency patient be seen regardless of insurance status or ability to pay is a critical feature of our nation's safety net and emergency care system. It also frees emergency clinicians to focus on patient care first, and everything else later. As a result, emergency departments are a truly egalitarian safety net: equitable access is guaranteed.

However, EMTALA also creates an unfunded care mandate, which necessarily contemplates shared stewardship requiring a balance of higher and lower payments. The frequent delivery of underpaid

[1] Cairns C, Kang K. National Hospital Ambulatory Medical Care Survey: 2021 emergency department summary tables. Available from: https://ftp.cdc.gov/pub/Health_Statistics/NCHS/ Dataset_Documentation/NHAMCS/doc21-ed-508.pdf.

and non-reimbursed services makes the reimbursement rates of other payers, including Medicare, absolutely critical:




For some of our members, commercial patients may make up only 10% of volume, but they make up 28% of overall revenue. That supports the equilibrium that is necessary to fund the important patient-access provisions of EMTALA. However, in rural EDs, the number of low-income patients who may be uninsured or under-insured (e.g., those with high-deductible health plans) is frequently higher than the national average, which creates an imbalance in the shared stewardship model because it results in unsustainably high levels of outstanding balances for rural providers from patients unable to pay. It is important to note that high-deductible plans functionally create self-pay patients, as the patient may have to shoulder *100%* of the bill for a necessary emergency visit. Patients may only be able to pay 15% of their responsibility and, since high-deductible plans allow the insurance company to wash its hands of the entire episode, that leaves the provider to absorb the remainder.

We would be remiss not to mention that unsuccessful implementation of the *No Surprises Act* has piled additional pressures onto emergency providers, and we thank the Committee for its ongoing attention to the very real implications of the NSA's troubled implementation, especially for rural, underserved, and vulnerable populations.

***Sustainable Provider and Facility Financing:*** *The Committee is requesting comments on policies that support the long-term health of medical providers and facilities to ensure access to care for patients in rural and underserved areas. This includes proposals to simplify and streamline Medicare's outdated patchwork of rural hospital adjustments and designations while ensuring adequate payments for safety net hospitals. Comments should describe improvements needed to Medicare payment systems and structure to incentivize providers to operate in rural and underserved areas. Feedback is also requested on regulatory or financing changes needed to ensure facilities in rural areas maintain critical inpatient services while promoting access to specialized services, such as maternity care.*

With regard to provider reimbursement, the Medicare Physician Fee Schedule's lack of a mechanism to reflect annual inflation and the annually proposed reductions largely due to statutory budget neutrality requirements have created an unstable, volatile reimbursement environment for Medicare providers. Although that impact is not unique to emergency medicine, it is far more pronounced for us because of the unique dynamic surrounding EMTALA described above. The EMTALA mandate – especially when coupled with underpayment by Medicaid and high levels of uninsured patients – leaves emergency providers with no "breathing room" to respond to downward pressure on reimbursement from other payers. EDPMA member experiences note that these effects are particularly pronounced in rural health care environments. Congress must reform the Fee Schedule to avoid annual reductions and provide stability to providers, as well as support payment sufficiency in the Medicaid program.

With regard to facility financing, there is currently a patchwork of different designations for rural facilities, which may frustrate those seeking a single, unified, national approach to Medicare payment to

rural facilities. However, each designation is intended to address a different challenge. For example, as the name suggests, the low-volume adjustment assists facilities dealing with extremely low volumes of patients, while the critical access designation was created in response to a wave of rural hospital closures and is intended to create more financial resilience for rural facilities. If the Congress believes the time has come to review the various rural adjustments and designations from a comprehensive perspective, perhaps the place to begin is with a Government Accountability Office study of the full Medicare rural facility payment landscape and the effectiveness of these various provisions in ensuring access to care for rural beneficiaries. That would provide Congress with the kind of assessment needed to formulate sound policy reforms, where needed.

As a general matter, Medicare's reimbursement structure for rural care rests on the idea that, if a community cannot support an inpatient unit, it does not need a hospital. Although freestanding emergency departments may help meet the need for emergency care in those communities, the lack of a hospital facility may create inequitable outcomes for patients whose emergency is one where time equals morbidity and access to specialist services is critical, such as sepsis, trauma, or stroke. While the new Medicare designation of Rural Emergency Hospital (REH) introduced by the *Consolidated Appropriations Act, 2021* seeks to address the issue of access to care in communities that cannot support an inpatient service, the REH designation is *only* available to hospitals that had an inpatient service as of December 27, 2020 to *convert* to REH status. Statute does *not* provide an option for an REH to open in a community that would benefit from access to REH services, unless the facility was an existing inpatient or critical access hospital at the time of passage of the *Consolidated Appropriations Act, 2021*, nor does the statute provide a conversion option for previously established critical access hospitals that closed prior to that date.

**Health Care Workforce:** *The Committee is requesting comments on policies to revitalize the health care workforce across the country to improve patient access to care, especially in rural and underserved areas. This includes policies that develop new providers and specialties in areas of the country where shortages are most acute, encourage providers to spend more time on patient care than paperwork, and ensure independent practice remains a viable option in a highly consolidated health marketplace. Comments should address existing barriers that prevent health care professionals at all levels from best providing health care services for patients. Feedback is also requested on how policies like nursing home staffing mandates at the state or federal level impact the health care workforce availability in other settings of care and the adequacy of how graduate medical education (GME) slots are being distributed in rural America.*

It is critical to maintain quality standards despite economic constraints in rural areas. Telehealth can provide a solution to improve specialty access in remote areas, but reimbursement remains at a level where the full value of telehealth has yet to be fully deployed to help solve the rural access problem. The goal should always be to have a board-certified physician on site to directly deliver care. However, in regions where geographic or economic conditions do not allow this level of care to be present, appropriate reimbursement should exist for consultative services delivered via telehealth and for supervision via telehealth of advanced practice providers (APPs), in situations where board-certified physicians cannot be staffed despite reasonable and maintained efforts by the hospital.

***Innovative Models and Technology:*** *The Committee is requesting comments on policies to advance innovative care models and technology, especially those that improve access to care in rural and underserved areas. This includes examples of successful models or technology which improve patient outcomes in rural and underserved areas. Comments should address proposals that can be replicated at the federal level while ensuring providers with limited resources can participate. Feedback is also requested on how recent Medicare flexibilities may have bolstered access to care. Thought should be given to addressing how these policies can maintain and not diminish quality of care or increase overall costs to taxpayers.*

**Improving access via telemedicine**. We thank Congress for extending through 2024 pandemic-related telehealth flexibilities resulting from the pandemic, and we urge you to make these flexibilities permanent. Removing unnecessary barriers to the provision of telehealth was a critical first step, but we must also ensure adequate levels of reimbursement for all remote care, which would ensure a higher level of accessible, appropriate-level care in rural communities. Since full access to all specialties is not yet completely accepted for reimbursement purposes, patients in need of specialist or higher-level care often require a transfer out of the rural facility. Given that transfers are expensive – and cost the patient valuable time – a key priority of Medicare should be to make such services more readily accessible via telemedicine. Such reimbursement should not only account for professional services, but also the technical payment associated with any necessary technology.

**Transitional care**. Outcomes research shows that support in patient navigation and way-finding is effective following an ED visit. That may involve facilitating access to ambulatory follow-ups, but it may also involve non-clinical services, such as help locating a social worker. However, payers currently do not reimburse much for such services, if at all, following an outpatient emergency department visit. Yet these services are a value proposition, insofar as they can help patients identify resources in the community that may help avoid utilization of further medical services, including return visits to the ED.

**Emergency medical services (EMS)**. There is a crisis in rural transport services. A recent review of geographic disparities in the provision of ambulance services found that eight states had fewer than *three* ambulances covering every 1,000 square miles of land area. Although there are reimbursement solutions that should be explored as well, from a simple logistical perspective, releasing EMS crews back to the community sooner after calls will free them up to respond to additional calls, and reduce wait time for patients experiencing emergencies that require transport. Leveraging telehealth to provide access to emergency medicine physicians in the field to help deliver care and direct the patient to the appropriate care destination prevents unnecessary re-transfer to a larger facility. By improving access to specialty care in rural settings, telehealth can help prevent unnecessary patient transfer to a larger facility in many situations and facilitate returning EMS to service sooner.

**Emergency care models**. In addition, there are several past and ongoing emergency care models that could be considered for replication by Medicare:

Metro Community Provider Network (Colorado): Bridges to Care Model

- Supported post-ED patient navigation and utilization decision-making
- On-site patient engagement during an ED visit for frequent ED patients
- Included work with SDOH, substance abuse and mental health patients
- Findings: Significant reduction in ED visits and program savings
- Using an initial ED visit as a real-time patient engagement opportunity is particularly effective

State of Maryland: Global Budget Payment Reform

- Hospital revenue is independent of patient volume or services delivered
- Subsequent studies evaluated ED visits/1,000, admissions from the ED, and ED returns (at 72h and at 9 days)
- Findings: Lower ED utilization, ED returns, and admissions
- Stable mortality and ICU stays among returns
- Economic alignment with hospitals can safely reduce total cost
- However, opportunities to address disparities among ED returns were identified

Acute Unscheduled Care Model (AUCM- proposed)

- Risk-bearing APM for emergency medicine that promotes safe discharges to home while reducing overall cost
- Goals: reduce hospitalizations, foster care coordination, and reduce post-ED safety events after an initial ED visit
- Includes waivers for telehealth, home visits, and transitional care management for emergency physicians
- Behavioral health patients included in mature phase
- PTAC recommended full implementation to HHS in 2018
- Findings: ED-centric model leverages patient engagement from an initial ED visit to achieve program goals
- Extends emergency physician/department accountability in a value-based model
- Proposed model not yet implemented, but similar models are used with commercial health plans

Emergency physician partnerships with health plans

- Value-based engagements with commercial payors (commercial plans; Medicare Advantage)
- Utilizes principles of the AUCM model (safe discharges, navigation, care coordination, quality measures)
- Flexible structure includes various levels of economic risk and reward
- New resource requirements are offset by program savings
- Findings: High patient engagement rates through direct follow-up from physician group
- Notably reduced ED return visits, patient experience improved, reduced overall cost

We would be pleased to provide additional details on any of these models, should they be of interest to the Committee.

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In closing, EDPMA thanks the Committee for this opportunity. We share the goal of ensuring that Medicare beneficiaries in rural areas can easily access high-quality medical services, including emergency care. Should you have any questions or need additional information, please contact EDPMA's Executive Director, Cathey Wise, at cathey.wise@edpma.org.

Sincerely,

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