The Honorable Jason Smith
Chairman of the Ways & Means Committee
United States House of Representatives
1011 Longworth House Office Building
Washington, D.C. 20515

October 4, 2023

Dear Chairman Smith:

The National Association of Freestanding Emergency Centers (NAFEC) thanks you for the opportunity to share our views on ideas to improve access to health care in rural and underserved areas.

Background on freestanding emergency centers

Freestanding emergency centers (FECs) are facilities that provide 24-hour emergency services to patients at the same level as hospital-based emergency rooms. Freestanding emergency centers offer the same services as hospital-owned off-campus emergency departments. The only difference between the two facilities is ownership, not capabilities. Our physician leaders typically left their hospital-based positions to get closer to patient care and away from bureaucracy and pressures to admit patients. The vast majority of these facilities have opened since 2010. There are approximately 200 freestanding emergency centers (FECs)[1] and they are concentrated mostly in Texas and Colorado. FECs are regulated and licensed by states and must comply with federal and state EMTALA laws as well as the No Surprises Act, which require treatment of all patients regardless of ability to pay and prohibits the charging of copayments for out-of-network care that exceeds that of in-network providers. FECs improve access to emergency services, offer essential, high quality and more convenient emergency care, and significantly reduce patient wait times.

FECs offer a solution to both overcrowded emergency rooms in urban areas and lack of access to emergency care in rural communities.
Freestanding Emergency Centers:

[1] Medicare Payment Advisory Commission. Report to Congress: Medicare and Health Care Delivery System. Chapter 2: Using payment to ensure appropriate access to and use of hospital emergency department services. pg. 42 (June 2018).

- Operate 24/7/ 365 and have highly trained ER physicians and nurses on-site at all times.
- Remain fully equipped for all emergencies and provide around the clock laboratory and advanced imaging services.
- Maintain a full pharmacy supplied with emergent medications, beyond the scope of physician offices or urgent-care centers.
- Diagnose, treat and stabilize all major medical emergencies, including heart attack, stroke and trauma.

Importantly, unlike hospitals, FECs do not have an economic incentive to admit patients to fill empty hospital beds. Recently published peer-reviewed literature shows that FECs can lower health care costs. When comparing FECs to hospital-based ERs, Simon et al. observed a 20% lower admission rate for conditions such as chest pain, COPD, asthma, and congestive heart failure (CHF).[2]

Rural Hospital Closures Threaten Critical Patient Access to Emergency Care

Currently, patients in rural areas struggle to access emergency services and access continues to get worse. Since 2010, 156 rural hospitals have closed, and another 15 rural hospitals have closed their doors this year, which is more than double the amount from last year.[3] These hospital closures exacerbate access issues in rural areas, especially for emergency care, as patients are compelled to drive long distances to receive emergency treatment.

The situation could deteriorate further. A recent report from the Center for Healthcare Quality & Payment Reform found that more than 600 rural hospitals, which represents 30% of all rural hospitals, are at risk of closing.[4] More rural hospital closures puts 60 million Americans in rural areas at risk of having limited or no real access to emergency services.[5]

Closure of rural hospitals causes residents to delay or forgo treatment due to increased travel time.[6] A study by the National Bureau of Economic Research found that hospital closures exacerbate already existing health disparities and increase mortality rates by 5.9

[2] Simon El, et al. Variation in hospital admission rates between tertiary care and two freestanding emergency departments, American Journal of Emergency Medicine (2017).
[3] Rural Hospital Closures. Cecil G. Sheps Center for Health Services Research. The University of North Carolina
[4] Rural Hospitals at Risk of Closing, Center for Healthcare Quality & Payment Reform.
[5] One in Five Americans Live in Rural Areas. United States Census Bureau. April 09, 2017.
[6] Wishner, Jane, et al. A Look at Rural Hospital Closures and Implications for Access to Care: Three Case Studies. Kaiser Family Foundation. July 07, 2016.

percent.[7] Moreover, when a hospital closes, per capita income in the community falls by nearly 4 percent because so many people rely on these facilities for employment and a necessary part of a community infrastructure.[8]

FECs Are an Important Solution for Improved Access in Rural Communities

FECs are eager to be a solution for this rural health care access crisis and have been working with Congress to establish permanent Medicare recognition. With the ability to pursue permanent Medicare recognition, FECs will then have a pathway to also secure Medicaid certification and TRICARE recognition. This will allow for expansion into rural areas that need improved access to emergency care.

FECs are efficient sites of care that do not carry the substantial fixed costs of building and staffing numerous, often vacant, operating rooms that hospitals are required to have, nor do they need to be focused on trying to recruit and maintain physician specialists (other than ER physicians) in remote areas where they tend not to reside. Because FECs can maintain low overhead costs, they have a greater ability to serve areas that may be unattractive or unviable for hospitals. Congress recognized this potential when it authorized "Rural Emergency Hospitals" several years ago, which allow critical access hospitals and other rural hospitals to convert into a FEC. But that law did not permit an FEC that was not first a hospital to obtain Medicare and Medicaid recognition.

Indeed, a key impediment to FECs expanding to rural areas is the current inability for this relatively new delivery model to qualify for Medicare and Medicaid reimbursement. Rural areas tend to have higher concentrations of Medicare and Medicaid beneficiaries, therefore building FECs in these areas is typically unviable may without Medicare and Medicaid reimbursement. These areas also include many military dependents who also need and deserve reliable emergency coverage under TRICARE. According to the American Hospital Association, Medicare and Medicaid comprise 56 percent of rural hospitals' net revenue.[9] Additionally, according to the National Center for Health Statistics, public coverage (Medicare and Medicaid) constitutes 46.5 percent of the rural population compared to just 37 percent of the urban population.[10] In order for FECs to be

[7] Gujral, Kritee, et al., Impact of Rural and Urban Hospital Closures on Inpatient Mortality. National Bureau of Economic Research. June 2020.

[8] Holmes GM, Slifkin RT, Randolph RK, Poley S. The effect of rural hospital closures on community economic health. Health Serv Res. April, 2006.

[9] American Hospital Association. 2019 Rural Report.

[10] Terlizzi EP, Cohen RA. Geographic variation in health insurance coverage: United States, 2021. National Health Statistics Reports; no 176: National Center for Health Statistics. 2022. Urban represents the sum average of "Large Metropolitan, Large Fringe Metropolitan, Medium and Small Metropolitan" and rural represents "Nonmetropolitan".

viable models in rural areas, it is vital that they have the ability to gain permanent Medicare and Medicaid recognition. Furthermore, prohibiting Medicare and Medicaid coverage in urban communities also deprives elderly and indigent patients access to timely, cost-effective emergency care.

For the last several years FECs have sought Medicare and Medicaid recognition, but as a relatively new industry, the federal statute has lagged behind health innovation and does not recognize this delivery model. However, in April 2020 FECs were able to secure a 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).[11] Over 110 FECs, mostly located in Texas, enrolled and were able to provide high quality emergency services to thousands of beneficiaries for all kinds of emergency conditions at a significant savings to the Medicare program. FECs effectively stepped up to alleviate nearby hospitals that were overwhelmed with COVID-19 patients and helped provide care for patients closer to their communities.

An actuarial analysis from Dobson-Davanzo that examined the Medicare claims data during this time period found that on a risk-adjusted basis, Medicare saved more than 20 percent for emergency care provided in FECs, compared to hospital ER. Additionally, 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. Texas ER utilization remained consistent with ER utilization across the United States after FECs gained temporary Medicare recognition. Essentially, not only are FECs able to increase access to emergency care without increasing Medicare costs, but they have the potential to save the Medicare program significant resources by providing more efficient care. We believe this is due to our nimble, patient-centered model, where patients are seen within minutes upon arrival and receive focused, individualized care . FECs are efficient and eliminate the typical hours of waiting time patients spend in overcrowded hospital emergency rooms where their conditions can worsen, and overworked providers often order a battery of potentially unnecessary tests and diagnostic procedures.

Unfortunately, the Congressional waiver which allowed FECs to be certified Medicare providers expired this past spring when the PHE ended. Action is now needed to reinstate that coverage.

The certainty of permanent Medicare coverage, and subsequently the ability to obtain Medicaid certification, will encourage FECs to locate in rural and underserved areas. FECs

[11] 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.

(and any other business) cannot make long-term decisions on entering a market, raising capital, building a facility and hiring staff without certainty. As such, we see a real opportunity to improve rural health care if Congress were to enact the Emergency Care Improvement Act (H.R. 1694), which was introduced by Rep. Jodey Arrington (R-TX) and Vicente Gonzalez (D-TX) with a host of cosponsors on the committees of jurisdiction from Texas and elsewhere.

The bill will improve Medicare beneficiary access to emergency care in rural areas and improve access and competition in urban areas by providing permanent Medicare and Medicaid recognition of FECs. The bill was endorsed by the American College of Emergency Physicians, the undisputed thought leader on emergency medicine.

In short, the Emergency Care Improvement Act provides Medicare reimbursement for qualifying FECs at the hospital rate for emergency services for moderate and high acuity ER codes. (There would be no facility reimbursement for patients with lower acuity -- levels 1 and 2 -- which pertain to patients that could typically be treated at an urgent care clinic.) FECs would be subject to the same conditions of participation for ER-related services and procedures as required of hospitals and must be licensed by states to provide such care. To ensure that FECs do not threaten volume and the economic viability of current rural hospitals, the bill would not provide Medicare recognition of FECs in a rural county that already has any type of hospital, including a rural emergency hospital.

The primary differences between Medicare recognition of FECs in H.R. 1694 and the newly created "Rural Emergency Hospitals" are two-fold:

1. Rural Emergency Hospitals must first be a hospital and then converted into a "rural emergency hospital;" FECs do not require that hospital conversion.

2. Rural Emergency Hospitals get paid 105% of the Medicare rate of hospitals; FECs would receive 100% under HR 1694.

Similarly, legislation (HR 1129) has been introduced to repeal the 35-mile limitation of how far a hospital-owned freestanding emergency department can be located from the mothership hospital. While that bill would eliminate an arbitrary constraint on FECs from assisting rural communities, it still retains a key obstacle: the FEC must be owned by a hospital. NAFEC believes the crisis in rural healthcare demands that ownership should not restrict type of licensed ER can serve a rural community. Clinical capabilities, not ownership, should be the paramount concern.

NAFEC welcomed the new federal recognition the No Surprises Act provided for freestanding emergency centers.[12] The NSA ensured that commercial insured patients receiving care at FECs received the same protections as patients receiving ER care in the hospital setting. It is time the Medicare law be similarly modernized and updated. Because the rural population is disproportionately covered by Medicare and Medicaid, Medicare recognition of FECs is critical for FECs to enter rural health communities. As such, Medicare recognition will not only improve access for Medicare beneficiaries in rural areas, but also all types of rural patients in those communities.

The closure of rural hospitals is a current and growing public health crisis. If nothing is done, America's rural population will be put at even higher risk. FECs want to help solve this issue and have a will to do so at a value to the system. We hope the Ways & Means Committee will consider H.R. 1694 as a key component in improving rural community access to health care.

Thank you for your kind consideration of this testimony. We look forward to working constructively and want to be a resource for you.

Sincerely,

Brad Shields
Executive Director
National Association of Freestanding Emergency Centers

[12] Section 2799A(a)(3)(D) of the Public Health Service Act