EMERGENCY MEDICINE COALITION OF DELAWARE

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November 13, 2017

BY EMAIL TO DELAWARE DEPARTMENT
OF HEALTH AND SOCIAL SERVICES AT
OurHealthDE@state.de.us.

Dr. Kara Odom Walker
Secretary of the Department of Health and Social Services
State of Delaware

RE: EMCODE and Delaware ACEP Comments on Delaware Road to Value

Dear Dr. Odom Walker:

Please accept this correspondence as written comments with respect to the Delaware Road to Value Draft referenced in an email from DHSS' Jill Fredel on October 25, 2017. I am submitting these comments on behalf of the Emergency Medicine Coalition of Delaware ("EMCODE"). EMCODE is a Delaware LLC, the members of which are directly involved with issues relating to the delivery of emergency medicine care to patients in Delaware. EMCODE from time to time comments on health policy matters and offers policy advice to Delaware elected officials and regulators on issues that relate to the delivery of emergency medicine services to Delaware patients. We are not making comments on behalf of the hospitals where EMCODE members deliver emergency patient care.

I am also submitting this letter on behalf of the Delaware Chapter of the American College of Emergency Physicians ("Delaware ACEP"). The College is a national organization that focuses on important issues that affect emergency medical care. ACEP's Federal and State advocacy revolve around the primary objective to insure that emergency care is there when it is needed in local communities, at the state level and nationwide.

EMCODE and Delaware ACEP have worked hand in hand since 2002 to advocate in Delaware for laws, regulations, procedures and funding to support and improve Delaware's emergency medical care system.

General Comments

First, we congratulate the Department and the individuals who undoubtedly worked hard to produce the Delaware's Road to Value Draft. The Draft certainly recognizes the need to address health care spending in Delaware in light of the fact that, among other things,

aggregate spending from Medicare, Medicaid and private insurance is projected to more than double between 2014 and 2025. The projections contained in the Draft actually understate the increases because they do not include patient payments and, more importantly to EMCODE and Delaware ACEP, the costs of indigent care. While these costs are not reflected in payments for medical care, they require that payments must indirectly subsidize the cost of care to our disadvantaged populations in order to ensure that this care is available to them when needed.

Just last week we learned that the Westside Family Health Care will close its Middletown facility largely because of growing challenges in recruiting clinicians and maintaining adequate funding. We all know that when people feel they are sick, they want to see a medical provider as soon as they can. When other resources are not available, the patients go to the Emergency Department ("ED"). At Beebe ED and Christiana Care's three Emergency Departments, we continue to see a growth in visits driven in part by issues that could have been treated through timely primary care but unfortunately treatment is delayed until an emergency evolves. Some of this delay occurs when patients postpone preventive care due to high deductibles or lack of access to primary care physicians, NPs, PAs and specialists.

Under the Federal 1986 Emergency Medical Treatment and Labor Act of 1986 ("EMTALA"), all individuals who come to an emergency department have a right to a comprehensive medical screening exam and the stabilization of their emergency medical condition, irrespective of an individual's ability to pay for care. It is estimated that over 50 percent of ED services go uncompensated either through a lack of insurance or when insurance payments do not cover the true cost of care. I am attaching a national ACEP information statement that highlights and expands on many of my comments in this letter.

Before I give you specific comments and suggestions on the Draft, I would like to give you some additional information on the delivery of emergency medicine services in Delaware. First, emergency medicine providers at Christiana Care and at Beebe Hospital will treat Delaware citizens through an aggregate of over 250,000 patient visits in 2017. This represents about half of the annual emergency department visits in Delaware Of course, many of these visits involve repeat patients but still the number of Delaware residents who will be treated in our EM departments in 2017 amounts to well over 100,000 individuals.

And what is the estimated reimbursed cost for medical care delivered in Emergency Departments? The cost is estimated at just under 2 percent of the country's health care dollars. The Draft states that in 2014 the total Delaware healthcare spending by Medicare, Medicaid and commercial insurance carriers was approximately $9.5 billion. Thus, of this amount using 2 percent as a reasonable estimate, approximately $190 million was paid to cover the costs of Emergency Department care in our state. The average per patient payment for the emergency physician component of emergency provider services at CCHS was only approximately $170.00. These payments are including payments from all sources and not coming exclusively from State revenues. The State's share is found in the Medicaid payments and payments for State employees and retirees.

Nevertheless, the payments are projected in the Draft to more than double by 2025. However, EMCODE and Delaware ACEP suggest that the Draft should recognize that the payments relating to the delivery of emergency care in Delaware are necessary, cost-effective and a small percentage of the total Medicaid and State payments.

We have recently witnessed the effect of three devastating storms that hit Florida, Texas and Puerto Rico especially hard. Terrorists recently killed and injured a number of people in New York City. Mentally unstable individuals killed 26 people in a rural church in Texas and killed and injured hundreds in Las Vegas. Last year, a terrorist killed and injured many people in an Orlando, Florida nightclub. In each of these tragedies, the injured were transported to emergency departments. If these emergency departments were not adequately staffed, many more victims would have died. Locally, we all know families (and in many case ourselves) whose loved ones were in a serious automobile accident or suffered a critical medical emergency and many of them survived because our emergency medicine system was adequately structured and supported to provide the care required.

Draft Related Comments and the Need for an Additional Section to focus on the need to protect the Delaware's Emergency Medicine System, Delaware's Primary Safety Net:

The first Section in the Draft that references emergency care providers is found under the topic Strategy II: Pay for Value. The applicable Section is titled Create reimbursement approaches for safety net services on prevention, care coordination and uncompensated care. This Section acknowledges that by focusing reimbursement strategies on prevention and primary care access, "vulnerable populations" should be able to better maintain provider continuity provided reimbursement approaches to "safety net providers" are adequate. If healthcare spending is restricted or fixed to medical providers, there is a substantial risk of access to care, especially acute care being also fixed or reduced Unfortunately, we are seeing that primary care networks are shrinking and Medicaid panels are likely being reduced because of perceived low Medicaid rates. As long as these panels shrink, EMCODE firmly believe that ED visits will continue to increase and reimbursement methodologies for emergency care must factor in these inevitable increases. If the primary care system can be stabilized and grow, emergency department visits might stabilize. Given current realities, the ED must continue to provide EMATALA mandated evaluation and stabilization for care delayed until it can be delayed no longer.

Reimbursement paid to safety net providers must not only be adequate but must be designed to protect and enhance our emergency care system both in the short and long runs. EMCODE and Delaware ACEP suggest that reimbursement policies should be based on an assumption that emergency room visits will continue to increase and that patients will need treatment for an ever increasing number of critical medical situations, due both to a struggling primary care system and an increasingly aging and medically compromised population.

The second Section in the Draft that references emergency medicine providers is found under the topic Strategy IV: Prepare And Support The Health Care Provider Workforce And The Health Care Infrastructure Needs. The applicable Section is titled Prepare for increased need for safety net providers. This Section specifically states that increasing the number of safety net providers and considering ways to increase reimbursement levels for them may be needed to meet the increased demand of services. EMCODE and Delaware ACEP support these comments.

However, EMCODE and Delaware ACEP suggest that another section be added to the Draft to recognize that providers and the hospitals cannot budget in advance for treatments to stabilize an emergency medical condition. Delaware law and regulation define Emergency Medical Condition as "a medical or behavioral condition, the onset of which is such that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

(1) Placing the health of the person or others in serious jeopardy;

(2) Serious impairment to the person's bodily functions;

(3) Serious impairment or dysfunction of any bodily organ or part of such person; or

(4) Serious disfigurement of such person".

We suggest that the new section in the final Plan recognize that all medical services performed at any time during the duration of an Emergency Medical Condition cannot, for the most part, be compensated within an all-payer model based on a prospective value-based reimbursement system. Such a model and reimbursement system must be constructed around medical services that can be anticipated.

For example, preventive primary care and cardiology medical services for a population, exclusive of a cardiac Emergency Medical Condition, arguably can be budgeted in advance based on best treatment protocols and the population to be served. The medical services required during a cardiac Emergency Medical Condition occurring within a population are substantially unpredictable. The number of patients presenting with such an Emergency Medical Condition will in part depend on the availability and effectiveness of preventive primary care. These services prior to the stabilization of the Emergency Medical Condition are delivered by many providers and institutions. In many cases, the first responders are paramedics from Delaware's statewide paramedic system, ambulance companies and local volunteer fire department EMTs. Once patients are transported to the ED, the medical team consists of nurses, physician assistants, nurse practitioners and emergency physicians. There are also numerous hospital support staff who are necessary for patient care. Next, there are physician consults and

diagnostic tests that must be performed under very difficult circumstances and at all hours, seven days a week. At some point, the patient (if conscious), the patient's family and the medical team agree on a course of treatment. The cardiac Emergency Medical Condition is still present; it hasn't ended until the treatment is completed and the patient is stabilized and admitted to the hospital or discharged in stable condition.

All of these services require resources that do not lend themselves to a prospective value-based reimbursement arrangement. We therefore suggest the Draft recognize that payments for Emergency Medical Condition treatments must for the most part continue to be based upon a fee-for-service model as opposed to a State mandated all payer model.

We also suggest that the Draft recognize that hospitals and emergency care providers must be free to analyze and perhaps implement alternative payment arrangements different from fee-for-service arrangements. We are asking that when it comes to the delivery of services for an Emergency Medical Condition, the providers should be free to negotiate payment methodologies and not be subject to a State-mandated approach.

I would also like to comment on the reference to "a prudent layperson" in the definition of Emergency Medical Condition. In the emergency medicine world, this reference is known as the Prudent Layperson Rule. This Rule is being questioned primarily by commercial health insurance companies. Health insurance policies cover necessary medical care. When it comes to emergency care, the care is necessary if a prudent person thinks it is necessary based upon the facts and circumstances of the situation. If the Prudent Layperson Rule is modified, carriers will not have to pay for emergency medical care that is now covered by their policies. Emergency care providers and their hospitals need the State to defend the Prudent Layperson Rule. EMTALA requires that the patient receive care even if the patient's health insurance company refuses to pay for the care because the Prudent Layperson Rule has been watered down. This result would mean an increase in uncompensated emergency services in Delaware which is the opposite of one of the objectives of the Road to Value.

Therefore we also suggest that the new section in the Draft reinforce the State's commitment to the Prudent Layperson Rule.

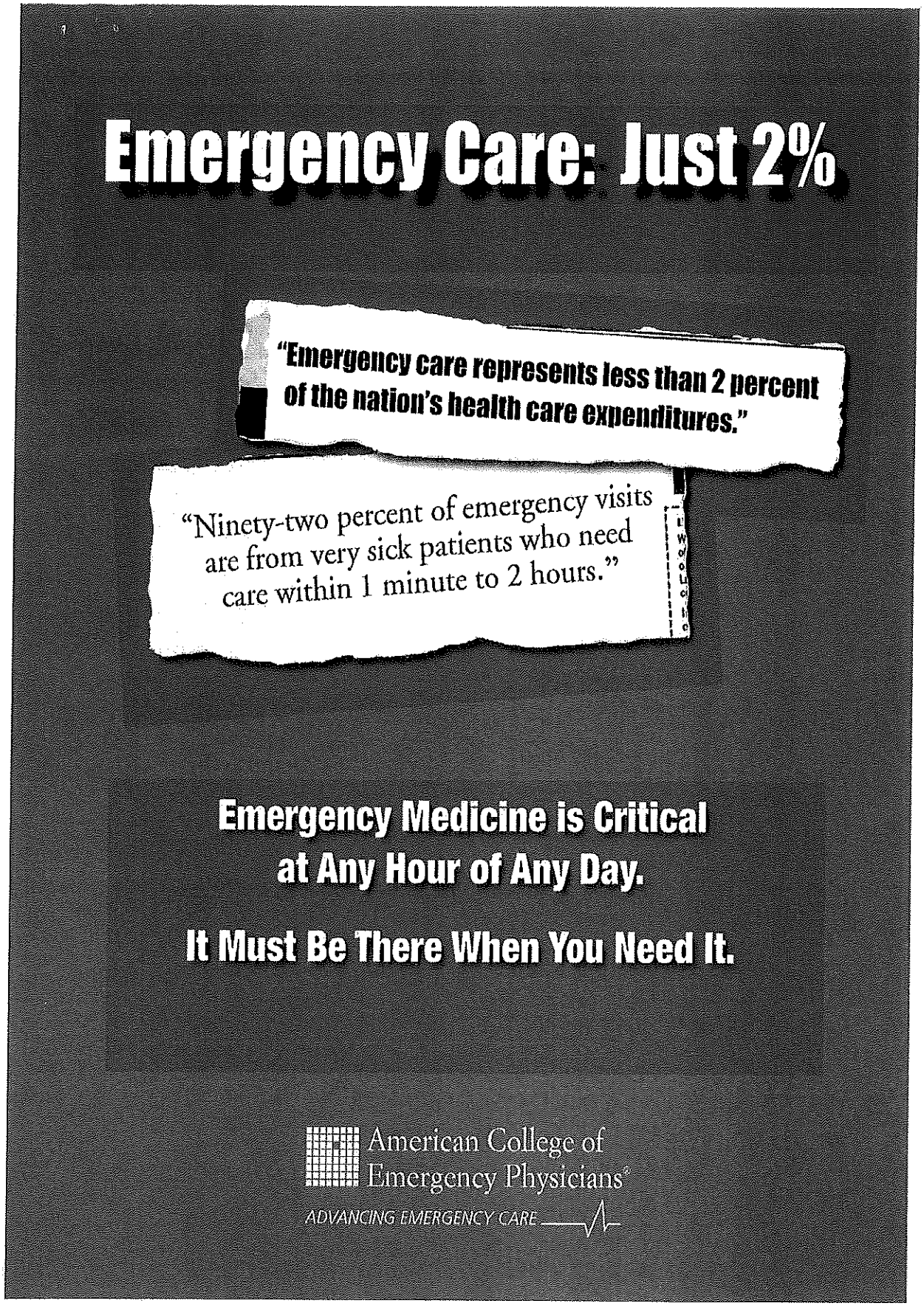
EMCODE would be pleased to submit suggested language for our requested new Section in the Road to Value outline if it would be helpful to DHSS.

EMCODE would also be more than pleased to sit down with you and/or other key members of state government to discuss in further detail how the proposed changes to healthcare financing can be implemented in a way that ensures continued access to emergency care for all the citizens of our state.

Very truly yours,

Leonard A. Nitowski, M.D.
President, EMCODE

cc: Katheryn Groner, M.D., President Delaware ACEP
John Powell, M.D. President Elect Delaware ACEP
Kevin D. Bristowe, M.D., President of Sussex Emergency Associates
EMCODE Members


Emergency Care: Just 2%
"Emergency care represents less than 2 percent of the nation's health care expenditures."
"Ninety-two percent of emergency visits are from very sick patients who need care within 1 minute to 2 hours."
Emergency Medicine is Critical at Any Hour of Any Day.
It Must Be There When You Need It.
American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

U.S. Health Care Expenditures and Emergency Care:

Can Emergency Visits Be Prevented? Will Significant Costs Be Saved?

Health care is a big business in the United States, representing more than 16 percent of U.S. Gross Domestic Product. Yet there are misconceptions about the costs and efficiencies of emergency rooms and "unnecessary" care. According to U.S. government statistics, emergency care represents less than 2 percent (1.9 percent)[1] of the $2.4 trillion[2] spent on health care.

Emergency care requires specialists, advanced technology and the tools to save lives within hours of entry into an ER. Can care be provided more cost effectively? Are there really "unnecessary" visits to the emergency room? And where do emergency visits fall within the bigger picture of health care spending and potential cost savings?

The need to reduce health care costs is clear. Health care expenditures increased to $2.4 trillion in 2008, according to the Department of Health and Human Services Office of the Actuary,[3] more than three times the $714 billion spent in 1990, and more than eight times the $253 billion spent in 1980.[4] Expenditures are forecast to reach $2.6 trillion in 2010. Since 1999, family premiums for employer-sponsored health coverage increased by 131 percent.[5] And many states, because of the economic crisis, are struggling to meet their health care budget obligations, particularly the rising costs of Medicaid.

What Percentage of Health Care Expenditures is Emergency Care?

The total U.S. expenditure on emergency care was $47.3 billion in 2008, according to the Agency for Healthcare Research and Quality.[6] This includes all services provided in the emergency department, including physician services. Given that total health care expenditures are estimated at $2.4 trillion in 2008, this means that emergency care represents less than 2 percent (0.019894896 percent) of the nation's health care expenditures.[7]

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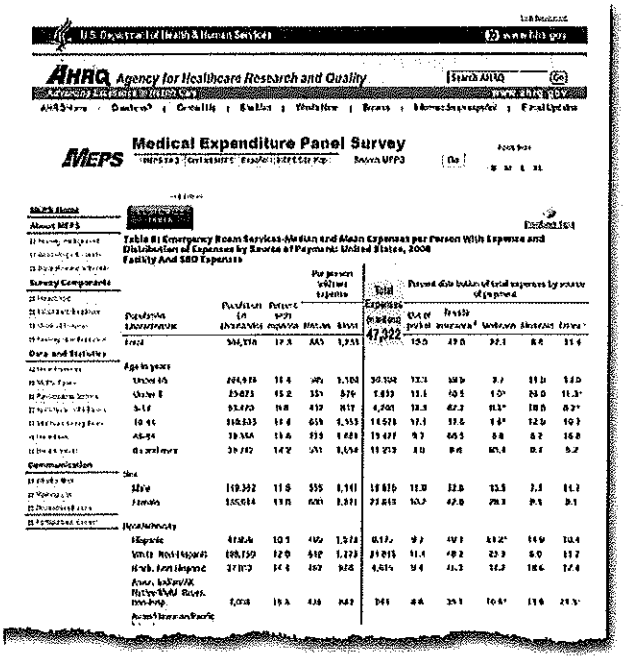


While it may cost more for patients to visit an emergency department than to visit a physician's office, the total cost is small relative to the entire health care system. Unlike a physician's office, emergency departments have all the diagnostic resources available 24 hours a day, seven days a week, 365 days a year, and the availability and use of this equipment contribute to the costs of care.

Emergency care represents less than 2 percent of the nation's health care expenditures.

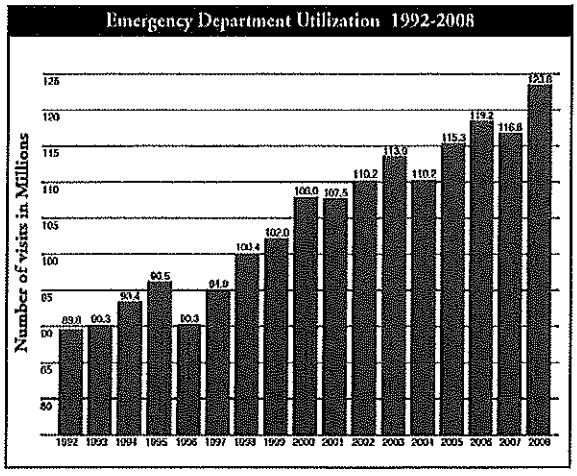
Overview of Emergency Care

Emergency care is a unique form of medical care. Emergency departments are available around the clock, and emergency physicians are medical specialists who are prepared to care for every type of medical emergency. They tap multiple resources on a daily basis within a hospital, such as diagnostic testing and consultation by other medical specialists, to respond to the emergency at hand; to set the course of a patient's diagnosis and treatment, including what happens after a patient has been admitted to the hospital; and to coordinate the further care of patients who can be discharged home directly from the emergency department.

Emergency physicians treat patients of all ages and all incomes. Unlike other medical providers, emergency physicians never turn patients away, primarily because of a moral obligation – but also because federal law requires hospital emergency departments to care for all patients, regardless of ability to pay. According to the American Medical Association, emergency physicians provide four to 10 times as much charity care as any other physician specialist.[8]

In 2008, there were nearly 124 million visits to the nation's nearly 4,000 emergency departments.[9] Two-thirds of the visits occurred after business hours and on weekends and holidays when doctors' offices were closed.[10] Ninety-two percent of emergency visits were from very sick patients who needed care within 1 minute to 2 hours. Emergency visits have increased at twice the rate of the U.S. population.[11] As the number of visits to the emergency department has increased, the number of hospital emergency departments has decreased from 4,019 to 3,833.[12]

Two-thirds of emergency visits occur after business hours, when doctors' offices are closed.



Can Significant Costs Be Saved?

According to the PricewaterhouseCoopers' Health Research Institute,[13] the top three areas of waste in the health care system are (1) defensive medicine (estimated at $210 billion annually), (2) inefficient claims processing (up to $210 billion annually), and (3) care spent on preventable conditions related to obesity ($200 billion annually).[14]

Nearly half (44 percent) of emergency physicians responding to a poll said the fear of lawsuits is the biggest challenge to cutting emergency department costs.

Reducing the practice of defensive medicine in emergency departments could result in significant cost savings. Emergency departments care for the most severely ill and injured patients who are most at risk of dying, which can result in lawsuits. Physicians will order a test out of fear of being sued for NOT ordering the test. Nearly 50 percent of emergency physicians responding to an ACEP poll said diagnostic testing was the largest expense on a patient's emergency department bill, and nearly half (44 percent) said the fear of lawsuits is the biggest challenge to cutting emergency department costs.[15]

Medical liability reform would help cut costs by reducing the amount of defensive medicine practiced by emergency physicians and other physicians treating patients in emergency departments.

The costs of staffing and equipping emergency departments to be ready to treat all patients with a myriad of conditions—24 hours a day, 7 days a week—are fixed. Given these requisite expenses, the extra (or marginal) costs of seeing an additional patient for an urgent or nonurgent medical problem are actually much less than the costs to open a private physician's office after hours or on the weekend, or to build an urgent care center.[16]

Are Most Emergency Visits Really "Unnecessary"?

Emergency medicine is essential to America, providing lifesaving and critical care to millions of patients each year, and most of the visits are necessary. Emergency physicians are at the front lines of any disaster—whether it's a multi-car crash on the highway or a shooting at a mall—and treat more than 120 million of the sickest patients each year using only 2 percent of the health care dollar.

Emergency physicians are at the front lines of any disaster—whether it's a multi-car crash on the highway or a shooting at a mall.

A federal report shows that 92 percent of emergency visits are for medical conditions that need treatment within 2 hours. The percentage of emergency patients seeking care for nonurgent medical conditions dropped to less than 8 percent (in 2007) and has been dropping since 2005 when it was 13.9 percent. The CDC defines "nonurgent" as "needing care in 2 to 24 hours." According to the CDC, "The term 'nonurgent' does not imply an unnecessary visit."

The fastest-growing segment of the U.S. population is patients over age 85. The rates of emergency visits by the elderly are increasing more rapidly than for any other group, and research has predicted this will lead to catastrophic overcrowding.[17] Elderly patients tend to be sicker and are more likely to be admitted from the emergency department to the hospital than other emergency patients.

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Emergency departments are prepared to diagnose and care for the most complex medical conditions, and physicians regularly refer their patients to the emergency department. Ninety-seven percent of emergency physicians responding to an ACEP poll reported that patients are referred daily to their ERs by primary care physicians.[18] In the same poll, 82 percent of emergency physicians reported that their emergency department saves lives on a daily basis.

Despite the growth of urgent care centers in America, emergency visits continue to increase. Part of the reason is because urgent care centers are not substitutes for emergency care. While urgent care centers can treat common medical problems when a physician's office is closed or unable to provide an appointment, they don't have the same equipment or trained staff that emergency departments keep ready on demand.

Dissuading patients from using emergency departments is not likely to be an effective strategy.

Many emergency physicians dedicate their lives to injury prevention and educating the public about how to prevent medical emergencies. However, the reality of the nation's population demographics, as well as physician shortages and an analysis of those seeking emergency care, show that dissuading patients from using emergency departments is not likely to be an effective strategy. In addition, the nature of emergencies, which are unscheduled events, and the needs of patients must be taken into account as policymakers and health care stakeholders develop new paradigms for how health care will be provided in the future.

What Goes into an Emergency Department Bill?

The costs of providing emergency care correspond to the severity of a patient's illness or injury. The bill will be higher when extensive diagnostic testing is necessary, such as when an emergency physician must treat a patient quickly without knowing the person's medical history (e.g., allergies, medical problems, recent medical procedures), which is often the case.

The major categories of an emergency department bill are not directly comparable to a bill from a primary care physician's office. The emergency bill may include fees for radiologists and other on-call specialists, pharmacy and other hospital services involved in the diagnosis and treatment of a patient. In an emergency department, physician consultations and medical tests are conducted in a few hours instead of a patient being referred to multiple medical providers over several days or weeks. The fee for an emergency physician's services on an emergency department bill typically is about 20 to 25 percent of the total charges for a visit. Hospital facility fees usually represent about two-thirds of the bill.

The most significant economic issue in emergency medicine, since the passage of the Emergency Medical Treatment and Labor Act in 1985,[19] has been uncompensated care. Charity care provided to uninsured patients and poor reimbursement by insurance plans, both private and public, have contributed to the closure of hundreds of emergency departments in the United States, straining the remaining ERs that care for increasing numbers of patients. Half of emergency services go uncompensated.[20]

Half of emergency services go uncompensated.

The new health care reform law[21] will add 16 million more people to the Medicaid rolls, which could reduce the rate of uninsured patients visiting emergency departments. However, since health insurance coverage does not guarantee access to medical care, many more people may seek care in emergency departments if they cannot find physicians who accept Medicaid because of its low reimbursement rates. According to a 2007 study, payments for emergency services declined for all patients over an 8-year period, with Medicaid paying less overall than uninsured patients do.[22] The proportion of emergency department charges paid were higher for uninsured patients (35 percent of the bills paid) than for Medicaid patients (33 percent of the bills paid).

What are the Biggest Drivers of Health Care Costs?

According to the Kaiser Family Foundation, the three biggest drivers of rising health care costs are (1) technology, (2) prescription drugs, and (3) chronic disease. The Congressional Budget Office (CBO) in 2008[23] said: *"... On the basis of a review of the economic literature, [the CBO] concludes that about half of all growth in health care spending in the past several decades was associated with changes in medical care made possible by advances in technology.... Major advances in medical science have allowed health care providers to diagnose and treat illnesses in ways that were previously impossible. Many new services are very costly; others are relatively inexpensive but raise aggregate costs quickly as ever-growing numbers of patients use them."*

Spending on prescription drugs will continue to be a cost issue, related to the aging population and the costs of prescription drugs. According to the Kaiser Family Foundation, the increases in prescription drug costs *"have outpaced other categories of health care spending, rising rapidly throughout the latter half of the 1990s and early 2000s. While the rate of growth in spending has slowed somewhat, it is projected to exceed the growth rates for hospital care and other professional services in 2010 and through 2019."*[24]

According to the Milken Institute, *"More than 109 million Americans report having at least one of the seven [chronic] diseases, for a total of 162 million cases....The total impact of these diseases on the economy is $1.3 trillion annually....On our current path, in 2023 we project a 42 percent increase in cases of the seven chronic diseases....Lower obesity rates alone could produce productivity gains of $254 billion and avoid $60 billion in treatment expenditures per year."*[25]

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4 "U.S. Healthcare Costs," Kaiser Family Foundation, March 2010, http://www.kaiseredu.org/Issue-Modules/US-Health-Care-Costs/Background-Brief.aspx.

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18 ACEP Poll, 2011.

19 Emergency Medical Treatment and Labor Act, 1986, https://www.cms.gov/EMTALA/.

20 "Decreasing Reimbursements for Outpatient Emergency Department Visits Across Payer Groups From 1996 to 2004," Hsia, R.Y.; MacIsaac, D; Baker, L.C.; *Annals of Emergency Medicine*. 51:3; 265-274.

21 "The Patient Protection and Affordable Care Act," Public Law 111-148, 2010.

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23 "Technological Change and the Growth of Health Care Spending," Congressional Budget Office, January 2008

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25 "An Unhealthy America: The Economic Burden of Chronic Disease — Charting a New Course to Save Lives and Increase Productivity and Economic Growth," Milken Institute, October 2007.

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