
# Using payment to ensure appropriate access to and use of hospital emergency department services

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April 5, 2018

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# Outline of today's presentation

- Background:
  - Emergency department (ED) use and stand-alone EDs
  - Payment incentives and ED use
- Urban stand-alone ED concerns
- Rural ED access concerns
- Discussion
- Vote on draft recommendations

# Growing ED use

- Medicare outpatient ED use grew faster than nationwide ED use and Medicare physician visits
- The two highest-paying levels of ED visits (levels 4 and 5) growing as a share of all Medicare ED visits
- Medicare outpatient ED payments increased 72 percent per beneficiary (2010 to 2016)
- Emerging trend: Stand-alone EDs
  - 550-600 operating in several states (2017)
  - Most opened since 2010
  - Approximately two-thirds are hospital-owned off-campus EDs (OCEDs) that can bill Medicare



Results are preliminary and subject to change.

# Payment incentives may be driving ED use

- Medicare pays two different rates for ED services
  - Type A payment rates: Facilities open 24/7
  - Type B payment rates: Facilities open less than 24/7, payment rates are 30 percent lower than Type A rates
- Medicare payment is dependent on the distance the OCED is from its affiliated hospital
  - Within 35 miles: Receives Type A payment rates
  - More than 35 miles: May not bill for ED services; instead receives physician fee schedule payment rates

# Urban stand-alone EDs: Concerns

- Number of stand-alone EDs growing in several urban markets
- Tend to locate in high-income areas
- Medicare payments misaligned with relative costs:
  - Lower patient severity than on-campus EDs
  - Lower standby costs than on-campus EDs
  - Paid the same as on-campus EDs (Type A ED payment rates)

# Identifying Medicare payment rates for OCEDs

- Acuity of OCED patients similar to acuity mix of Type B cases, and between on-campus hospital EDs and urgent care centers
- Type B payment rates are 30 percent lower than Type A rates
- Type B rates contain an anomaly: lowest intensity cases paid more than some higher intensity cases
- 30 percent reduction to Type A rates is more consistent with policy objectives

# Proximity threshold for urban OCEDs

- 75 percent located within 6 miles of an on-campus hospital ED
- 25 percent located more than 6 miles from an on-campus hospital ED

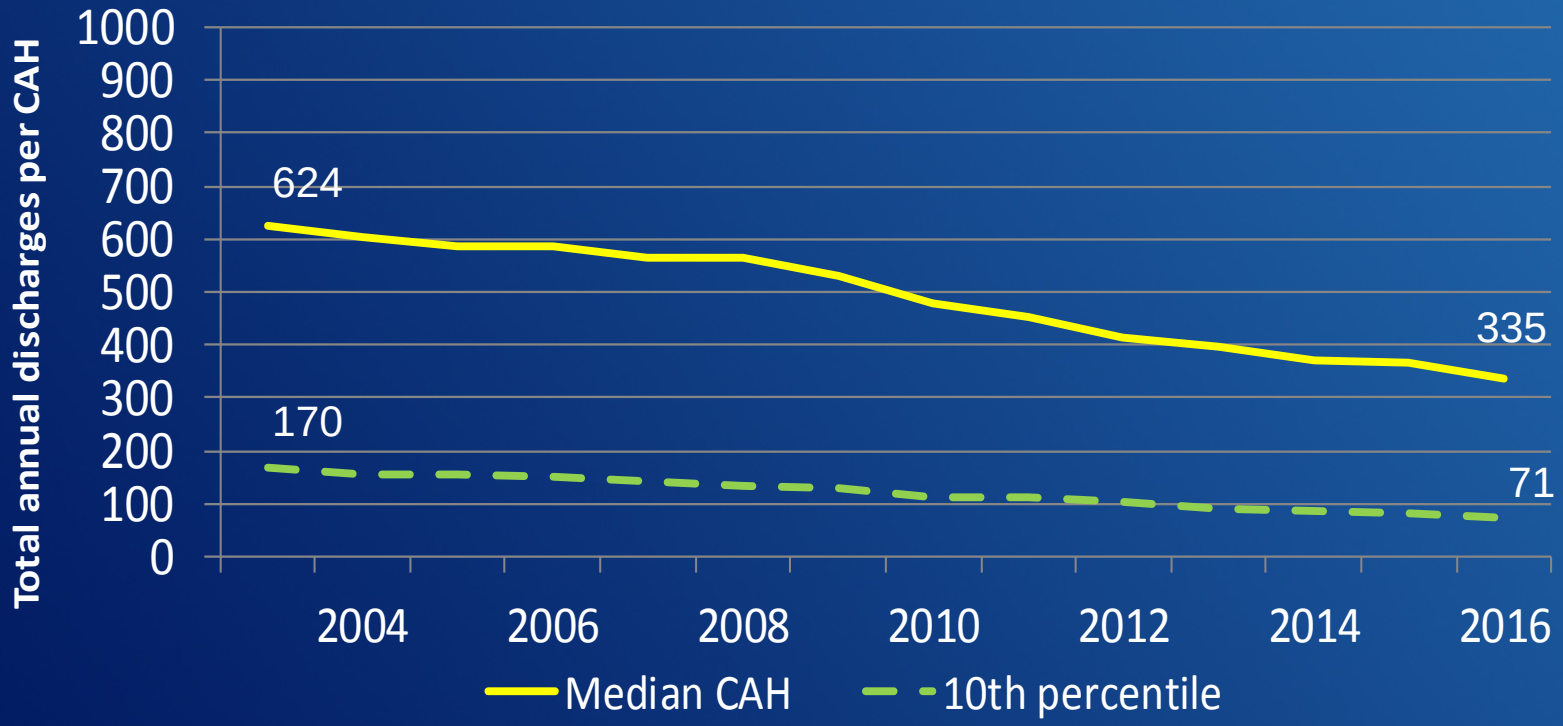
| | Distance to the nearest on-campus hospital ED (miles) | | | | |
|---|---|---|---|---|---|
| | 0-2 | 2-4 | 4-6 | 6-8 | 8+ |
| Cumulative percent | 21% | 52% | 75% | 87% | 100% |
| Average minutes to nearest on-campus hospital ED | 4.4 | 8.4 | 10.3 | 14.0 | 18.4 |

Source: MedPAC analysis of stand-alone ED locations using ARC GIS and google mapping.
Note: Data are for 112 stand-alone EDs in five US markets (Charlotte, Cincinnati, Dallas, Denver, Jacksonville).

# Rural concern: Inpatient-focused rural payment policies are increasingly ineffective

- Long-standing objective: Preserve access
- Current strategy
  - Higher inpatient rates for rural PPS hospitals
  - Cost-based payment for Critical Access Hospitals (CAHs)
- Two problems
  - Increasingly inefficient
  - Does not always preserve emergency access

# Declining admissions at CAHs




Source: All-payer discharges reported by hospitals on Medicare cost reports.
Results are preliminary and subject to change

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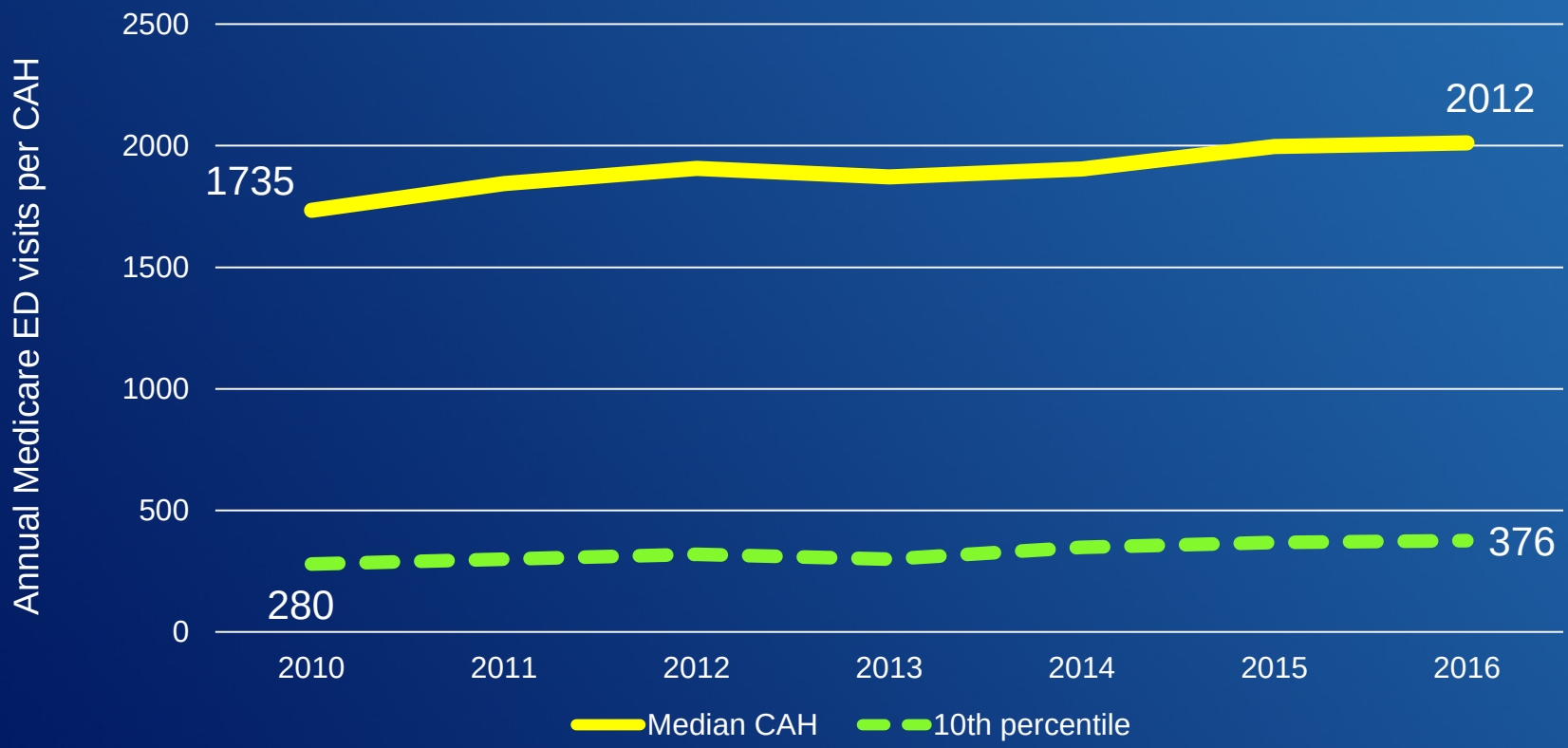
# Growing Medicare ED visits at CAHs




Source: Medicare cost reports.
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# Discussion topics

- Urban draft recommendation: Align payments to urban OCEDs with the cost of care
- Rural draft recommendation: Preserve access to rural ED services