

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

Jeff Stensland, Zach Gaumer,
and Sydney McClendon

April 5, 2018

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

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

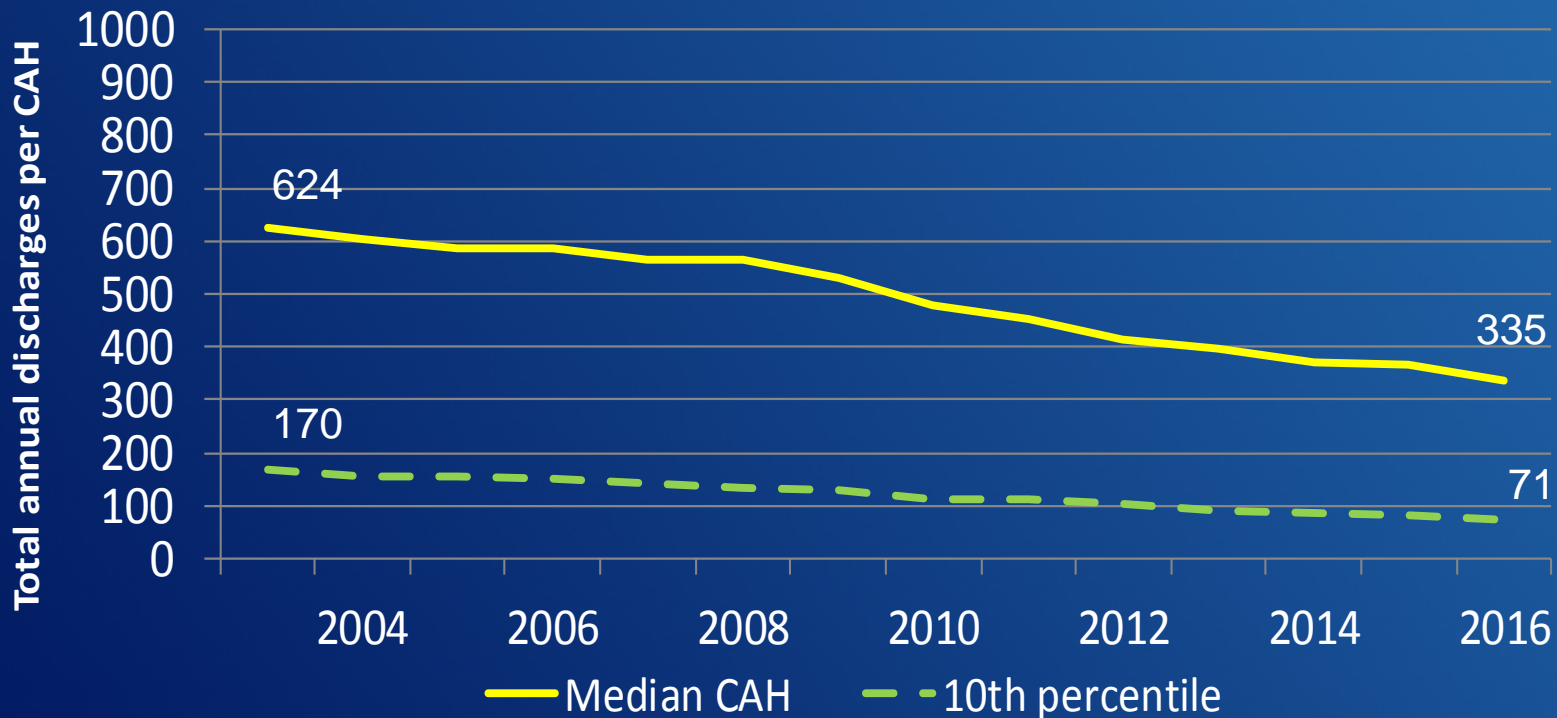
	Distance to the nearest on-campus hospital ED (miles)				
	0-2	2-4	4-6	6-8	8+
Cumulative percent	21%	52%	75%	87%	100%
Average minutes to nearest on-campus hospital ED	4.4	8.4	10.3	14.0	18.4

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

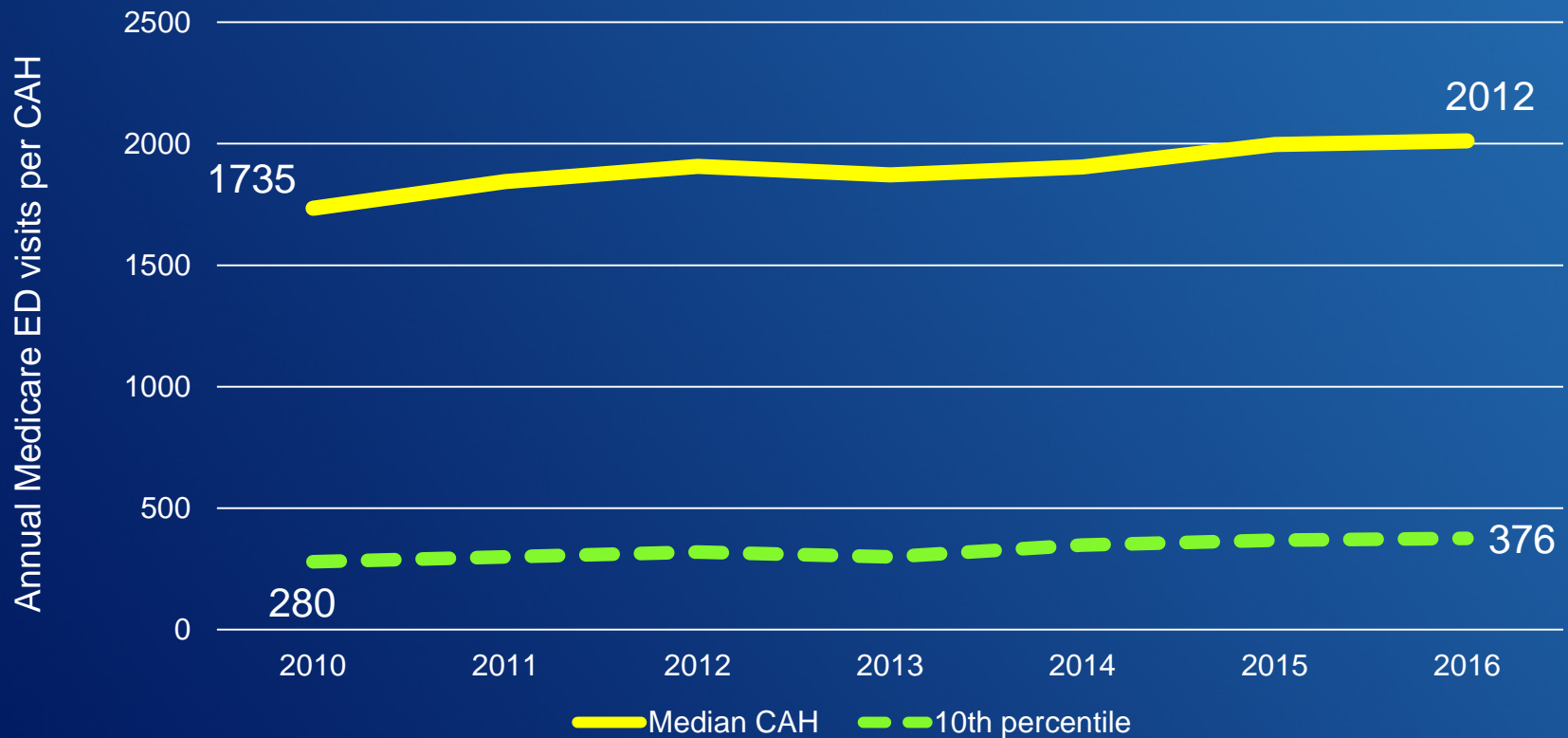
- Long-standing objective: Preserve access
- Current strategy
 - Higher inpatient rates for rural PPS hospitals
 - Cost-based payment for Critical Access Hospitals (CAHs)
- Two problems
 - Increasingly inefficient
 - Does not always preserve emergency access

Declining admissions at CAHs



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

Growing Medicare ED visits at CAHs



Discussion topics

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