Advising the Congress on Medicare issues

Improving incentives in the emergency department payment systems

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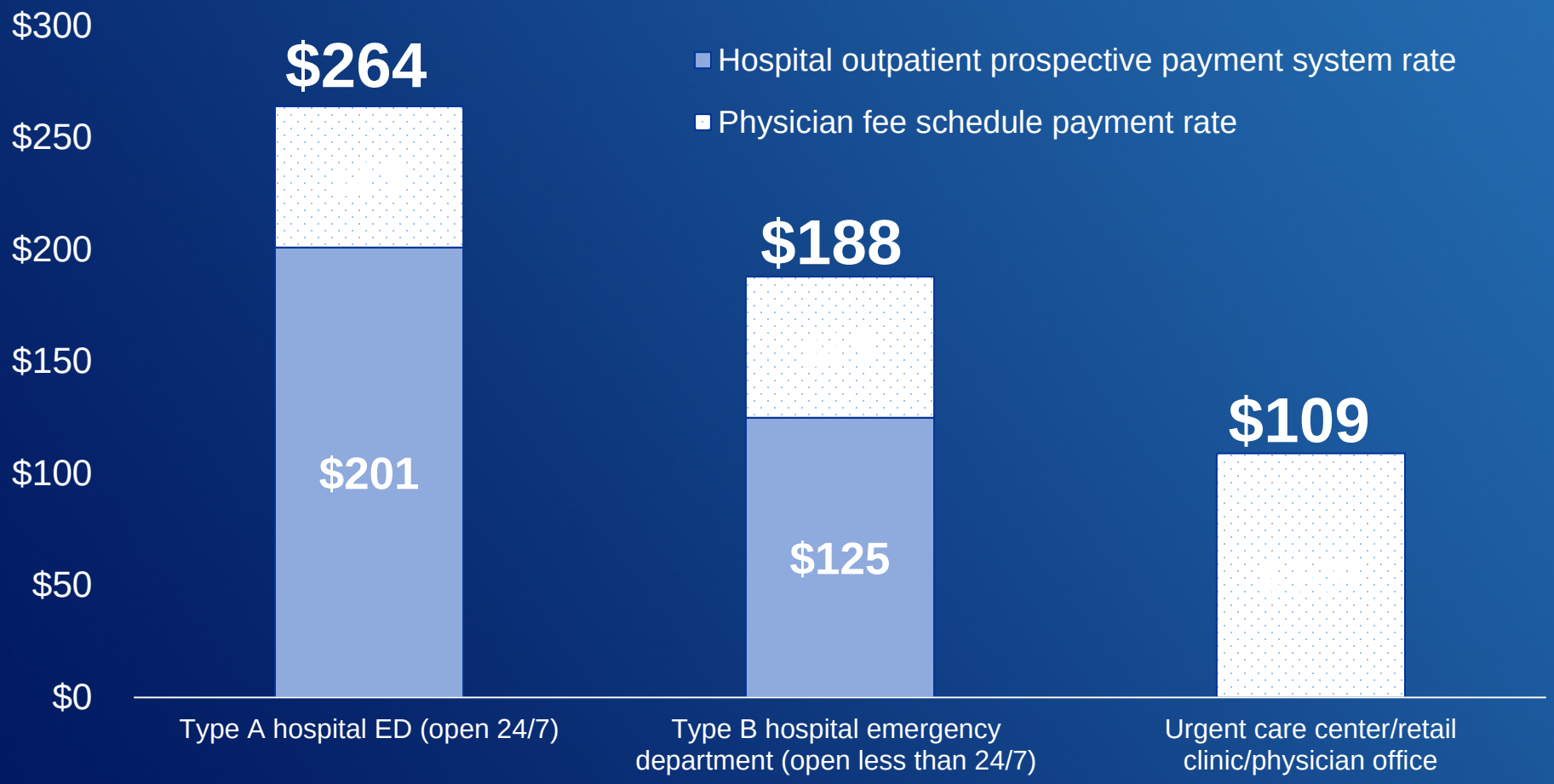
Outline of today's presentation

- Review the emergency department (ED) payment system
- Background on stand-alone EDs
- Urban stand-alone ED growth
  - Site neutral (Section 603) concerns
  - Payment concerns
- Rural ED access concerns
- Policy options to address concerns

Medicare payment for ED and urgent care center services (2017)



Note: The physician fee schedule (PFS) payment rates for services delivered in hospital EDs reflect level 3 physician ED services, and payment rates for services delivered in urgent care centers and physician offices reflect level 3 evaluation and management codes for new patients.

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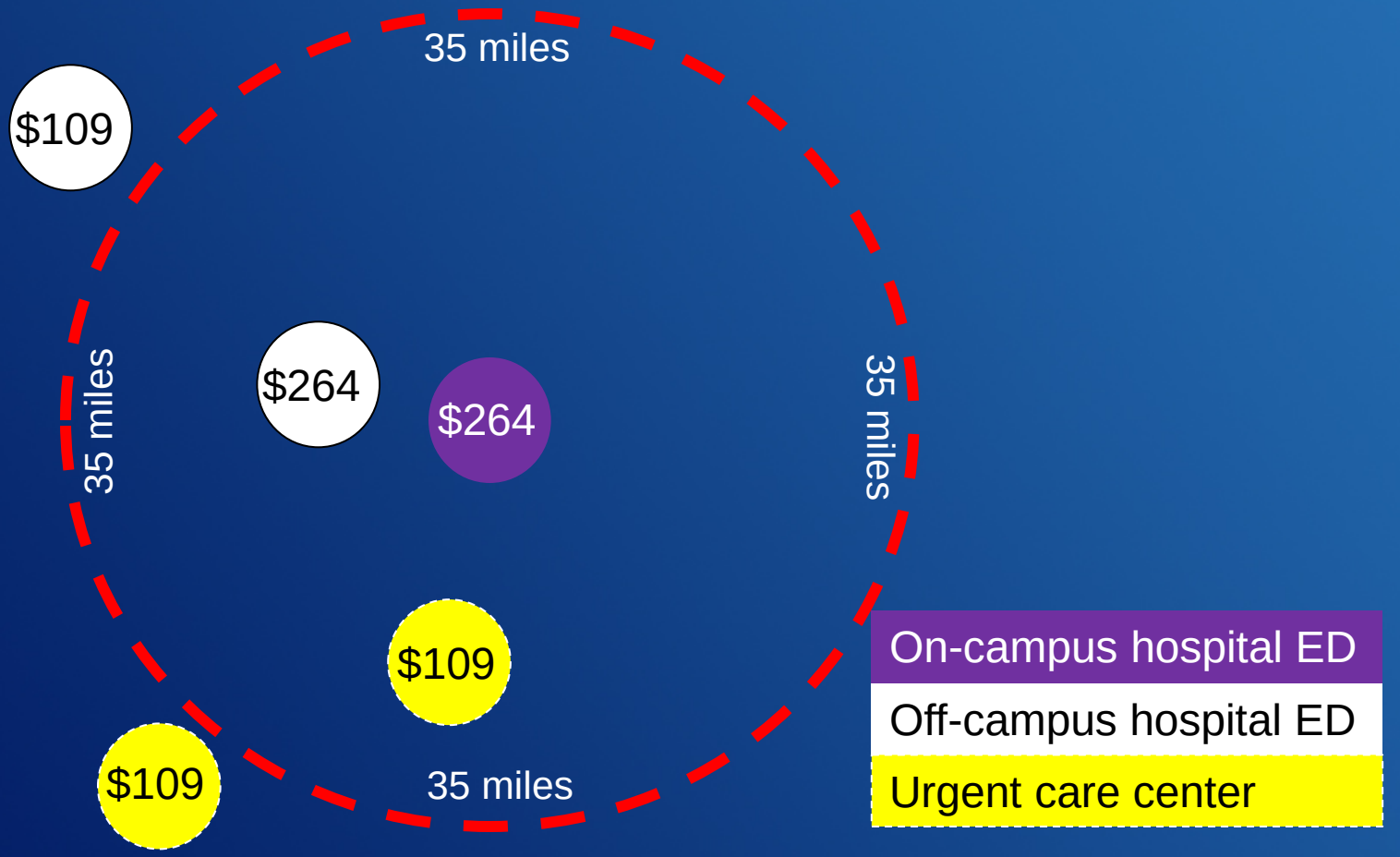
Stand-alone EDs

- Two types of stand-alone EDs:
  - Hospital-owned off-campus EDs (OCEDs)
  - Independent freestanding emergency centers
- 580 stand-alone EDs in operation
- Only OCEDs can bill Medicare (if deemed off-campus provider-based departments)

Illustrative example of Medicare ED payments by facility type and geography



Note: The ED payment amounts displayed are for level 3 Type A ED visits and for level 3 office visits at an urgent care center.

Concerns about urban stand-alone EDs

- The number of stand-alone EDs is growing rapidly in several urban markets
  - Tend to locate in high-income areas
- Patient severity falls between on-campus hospital EDs and urgent care center (e.g., TX, MD, CO)
- Lower standby costs than on-campus hospital EDs
- Equal payment to on-campus hospital EDs

Additional incentive to build OCEDs

- Section 603 of the Bipartisan Budget Act of 2015 exempted emergency departments from off-campus site-neutrality payment rates
- OCEDs can bill higher OPPS rates for emergency services AND non-emergency services (e.g., physician office visits, imaging)
- Creates incentives for health systems to co-locate off-campus physician offices within OCEDs

Section 603 policy option

- Current law: OCEDs receive facility fees for scheduled physician office visits
- Policy option: Pay physician offices co-located with OCEDs the same rates as off-campus physician offices
- Impacts of the policy:
  - Lower rates for OCED physician practices
  - Lower cost-sharing for beneficiaries
  - Less incentive to build unnecessary OCEDs

Urban policy option: Type B rates

- Resource needs of OCED patients between those of urgent care centers and hospitals' on-campus EDs
  - More ambulance transports to on-campus ED
  - More walk-ins at OCEDs
- Set payments to reflect the difference
  - Type B rates if urban OCED within 20 minutes of an on-campus ED
  - Type A rates for more isolated OCEDs

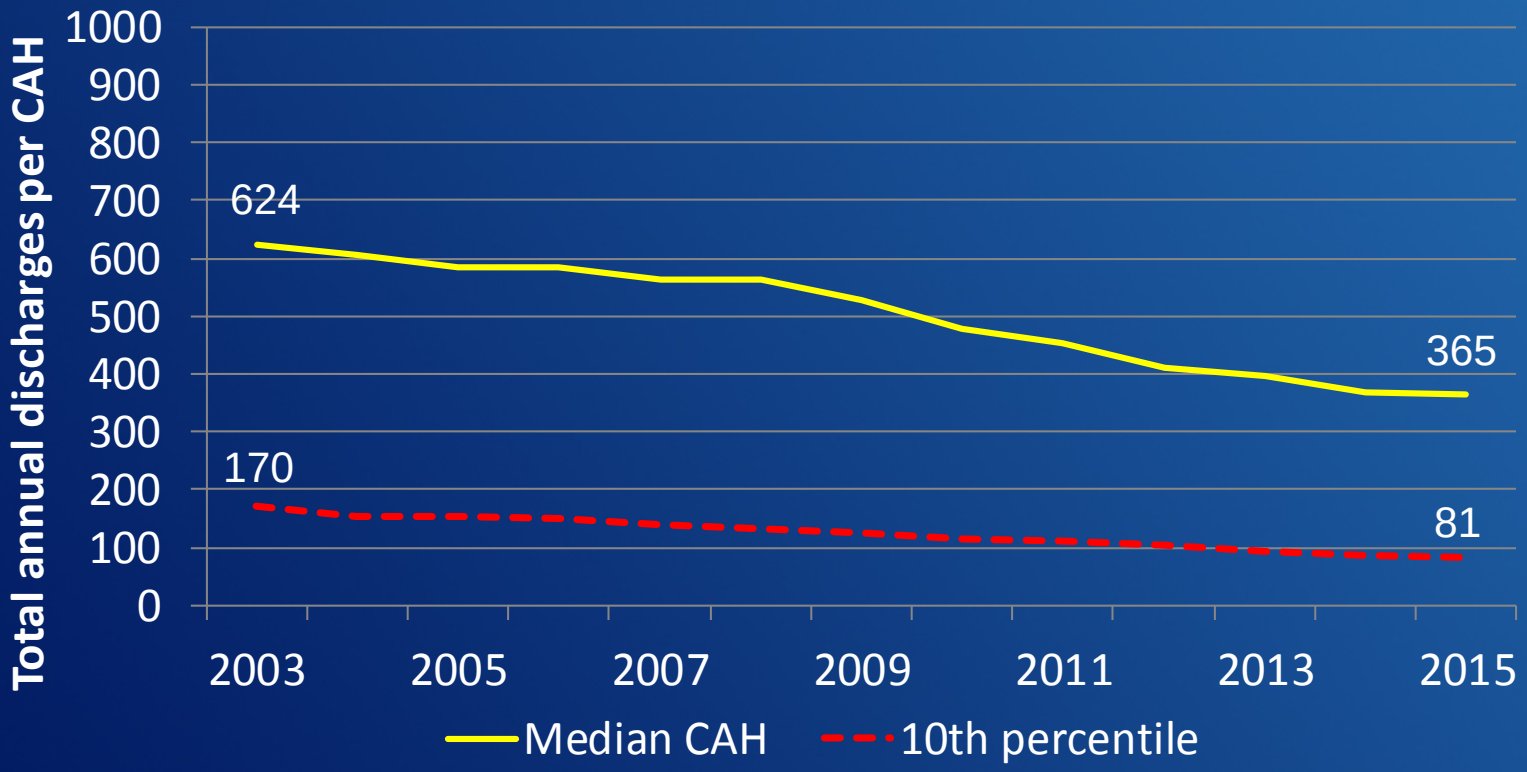
Effect of Type B rates for off-campus emergency departments

- Moderately lower Medicare rates for OCEDs (e.g., reduce from $264 to $188)
- Moderately lower cost-sharing for beneficiaries
- Reduced incentive to build EDs when urgent care centers could meet patient needs

Background on rural hospital payment policy

- 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 the hospital

Declining admissions at Critical Access Hospitals



Source: All-payer discharges reported by hospitals on Medicare cost reports
Preliminary results subject to change

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Cost-based payments do not always preserve access to emergency care

- 21 critical access hospitals closed from 2013 to 2017 (2 were more than 35 miles from another hospital)
- CAHs closed despite receiving a median of $500,000 in higher payments for inpatient and post-acute care
- Would emergency services have been financially viable if Medicare had redirected the supplementary dollars from inpatient to the ED?

Rural policy option: 24/7 emergency department in outpatient-only hospital

- Target isolated hospitals (e.g., 35 miles from other hospitals)
- Payment
  - Type A outpatient PPS rates per service
  - Fixed amount to help fund standby costs
    - Medicare provides a fixed amount
    - Local entities could be required to provide matching funds

Objectives of rural outpatient-only policy option

- Maintain emergency access in isolated areas
- Offset the cost of the additional ED payments with efficiency gains from consolidating inpatient services
  - Shift acute patients from low-occupancy to higher-occupancy facilities
  - Shift post-acute patients from high-cost CAH care to facilities paid skilled nursing facility PPS rates

Effects on providers

- Change is optional
- Provides a mechanism for financial viability when inpatient volumes fall below financially viable levels
- The outpatient facility will have supplemental funds that can help recruit physicians

Effects on rural beneficiaries

- Emergency access is maintained
- Patients will travel for inpatient care
- Lower coinsurance on outpatient services
  - Shifting from CAH coinsurance to PPS coinsurance will often reduce coinsurance by over 50 percent

Discussion issues

- Site-neutral rates for physician offices co-located with OCEDs (Section 603 fix)
- Type B rates for urban OCEDs within 20 minutes of an on-campus ED
- Retarget inpatient subsidies to stand-alone rural EDs