Advising the Congress on Medicare issues

Improving efficiency and preserving access to emergency care in rural areas

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MEDPAC

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
  - Becoming less successful in preserving access

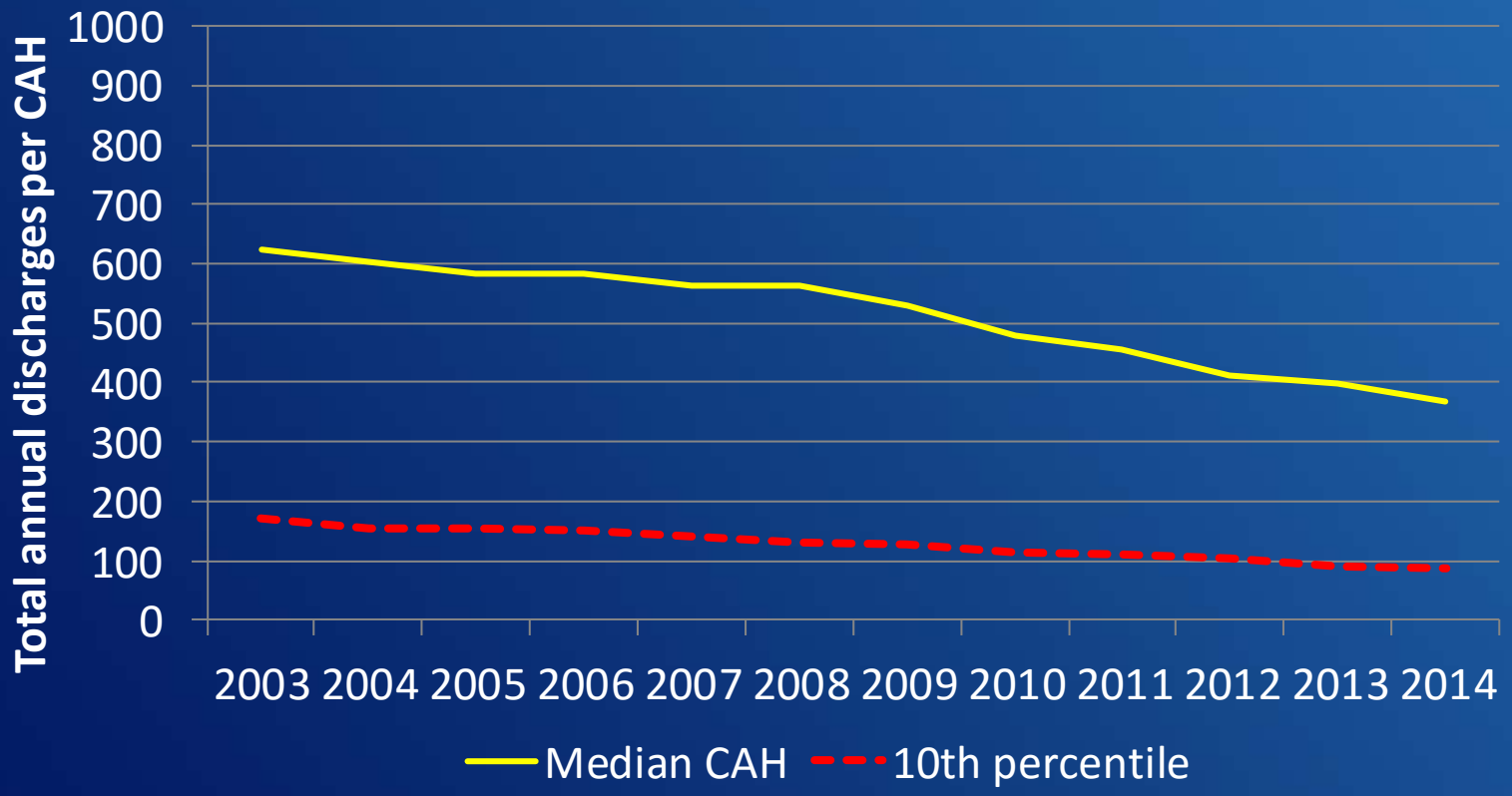
Existing strategies for preserving emergency access in rural areas

- Sole-Community Hospital (SCH), an add-on to inpatient rates (300+ hospitals)
- Medicare-Dependent Hospital (MDH), an add-on to inpatient rates (150 hospitals)
- Low-volume adjustment, an add-on to inpatient rates (can also be MDH/SCH)
- Critical Access Hospital (CAH), requires inpatient services (1,300 hospitals)

Limitations of existing models

- Inpatient-focused
  - Lower volume → higher unit costs
  - Lower volume → concerns about quality
  - Concern: Low volume can lead to low value
- Most rural hospitals are CAHs with cost-based reimbursement
  - Favors higher-profit/high-cost hospitals
  - Encourages non-emergency services (e.g., imaging and post-acute swing-bed services)
  - Can lead to excess cost growth

Declining admissions at critical access hospitals



Source: All payer discharges reported by hospitals on Medicare cost reports

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Declining volume and increasing closures

- 41 rural closures from 2013 to March 2016

  (54 rural closures if we include rural portions of MSAs)
- Distance to the nearest hospital varied widely among the closures
  - 3 are less than 10 miles from the nearest hospital
  - 24 are 10 to 20 miles from the nearest hospital
  - 13 are 20 to 30 miles from the nearest hospital
  - 1 is over 30 miles from the nearest hospital

Cost-based payments do not always keep hospitals open

- 14 of 41 closures were critical access hospitals
- For the median CAHs that closed in 2014, cost-based payments exceeded PPS rates by $500,000 for inpatient and post-acute care
- High costs per inpatient day absorbed the additional payments
- Question: Would emergency services be financially viable if we redirected the supplementary dollars from inpatient to ED services?

Goals of an outpatient-only option

- Isolated hospitals (CAH or PPS) would have the option to convert
- Maintain emergency access
- Improve efficiency
- Assure community commitment by requiring matching grants from the county or local sources

Option 1: 24/7 Emergency department

- 24/7 emergency department and primary care outpatient services
- Payment
  - Hospital outpatient PPS rates per service
  - Fixed grant to help fund stand-by costs
- No acute inpatient services
- Post-acute SNF services get PPS rates

Option 2: Clinic + ambulance

- Primary care clinic + ambulance
  - Clinic open 12 hours per day
  - Ambulance available 24/7
- Two types of payment
  - PPS rates per unit of service (e.g., FQHC rate)
  - Fixed grant to help pay for ambulance stand-by capacity and uncompensated care costs

Eligibility for special payments

- Focus on “low-volume isolated providers” (June 2012 MedPAC report)
- Isolated could be defined as being some minimum distance to nearest competitor

Remaining issues

- 24/7 model
  - Product: 24/7 standby emergency capacity
  - How will the ED be staffed?
  - Allow conversion back to CAH or PPS hospital?
- Clinic + ambulance
  - Product: what is Medicare buying?
  - Minimum staffing?
  - Maximum ambulance response time?
  - Limiting eligibility for the program?

Effects on rural beneficiaries

- Emergency access is maintained
- Patients will travel for inpatient care
- Outpatient services will be paid PPS rates and have lower coinsurance than at CAHs

Effects on providers

- Change is optional
- Can create financial viability
- The health care provider will have grant funds that can help recruit physicians
- Cost structures will be lower (PPS rates) making the entity more compatible with ACOs and the movement to value

Discussion issues

- Options
  - 24-7 ED stand-by capacity
  - Primary care and ambulance access
- Require matching grant funds from the county or local community?
- Allow hospitals (CAHs or PPS) that convert to an outpatient only facility to convert back to their original status?