

Models for preserving access to emergency care in rural areas

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Background: Admissions & closures

- Hospital admissions have been declining
- Hospital closures have been increasing
- Similar levels of rural and urban closures
- 30 rural closures since January 2013
(41 rural closures if we include rural portions of MSAs)
- Concerns about closures in rural areas that lack other sources of emergency access

Background on payment policy

- Long-standing objective: preserve access
- Current strategy
 - Supplemental inpatient payments
 - Cost-based payment
- Two key questions
 - What are the limitations of the current payment models?
 - What can Medicare do to preserve emergency access?

Limitation 1: Inpatient-centric models

- 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)

Admissions continue to decline for small rural hospitals

- Declines in total discharges per hospital from 2003 to 2013
 - Rural PPS hospital: -12%
 - Rural CAH: -27%
- Trend accelerating: From 2012 to 2013, CAH discharges declined by 4%
- Ten percent of CAHs (130 hospitals) had 2 or fewer discharges per week in 2013

Limitation 2: Cost-based payment

- Cost-based payment favors higher-cost hospitals
 - Some rural hospitals in poor communities choose PPS rates over CAH status
 - Higher-income communities have higher costs
- Cost-based payment favors product lines with high Medicare or private share
 - Post-acute care in swing beds
 - Imaging
 - Not emergency services
- Cost-based payment reduces incentives for cost control

Cost-based payments do not always keep the doors open

- CAH closures
 - 6 in 2013
 - 7 in 2014
- Closed despite supplemental dollars
 - \$550,000 in supplemental post-acute care payments per closed CAH in 2014
 - Higher payments consumed by high inpatient costs, leaving little for ED costs
- Could we redirect dollars from inpatient acute and post-acute care to ED services?

New payment options

- Rural free-standing emergency departments
- PPS payments alone may not allow them to be financially viable
- Two types of financial support for all services
 - Fixed grants to help pay for stand-by capacity costs, and
 - PPS rates for each service

Targeting special payments

- Focus on “low-volume isolated providers” (June 2012 MedPAC report)
- Isolated could be defined as being some minimum distance to nearest competitor (e.g., 20 or 25 miles)
- Minimum distance requirements could vary between the two models outlined below

Model 1: Emergency department

- Maintain 24/7 emergency department
- Payment
 - Hospital outpatient PPS rates per service
 - Fixed grant to help fund standby costs
- No acute inpatient services
- Post-acute SNF services get PPS rates
- Hospitals (CAH or PPS) could choose to convert to the outpatient-only model

Model 2: Clinic with ambulance

- Primary care clinic + ambulance
 - Clinic open 8 or 12 hours per day
 - Ambulance 24/7
 - Being examined in Kansas
- 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
 - Similar to FQHC model

Future issues

- How big should the fixed grants be?
- How should beneficiary coinsurance be handled?
- Should grants be tied to minimum levels of access to clinicians in an emergency?
- Require local government contributions?

Discussion issues

- Allow rural hospitals to move away from inpatient models?
- Is the PPS rate + grants payment approach reasonable?
 - The outpatient-only model with an emergency department
 - The clinic with ambulance model (without a 24/7 emergency department)
- Other questions or comments?