
# Stand-alone emergency departments

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# Context

- June 2016 report to Congress: Stand-alone emergency departments (ED) may be a possible solution for isolated rural areas with concerns about access to care
- Today's discussion: Stand-alone EDs in urban and suburban areas, where access to care may not be as much of a concern
- Rationale for revisiting stand-alone EDs:
  - Commission interest in continuing to track stand-alone EDs
  - The number of stand-alone EDs continues to increase, such that a national association has been formed
  - New academic research published this year
  - Section 603 of the Bipartisan Budget Act of 2015 (site neutral law) exempts some stand-alone EDs from the prohibition on off-campus facilities billing as hospital outpatient departments

# Hospital-based off-campus emergency departments (OCED)

- Affiliated with hospitals but located off-campus
- 363 OCEDs in 2016
  - 64 percent of all stand-alone EDs
  - Affiliated with more than 300 hospitals (6 percent of all hospitals)
- Limited set of services: 24/7 ED, imaging, on-site lab, on-site physician. No trauma services. No operating rooms
- Often less than 10 miles from hospital in urban/suburban areas
- Few patients arrive by ambulance
- Range in size (20 to 100 patients per day)
- May bill Medicare for ED services
- Private insurers often pay as in-network providers

# Independent freestanding emergency centers (IFEC)

- Not affiliated with a hospital
- 203 IFECs in 2016 (36 percent of all stand-alone EDs)
  - 94 percent located in TX, but also CO, MN, and RI
  - Owned by 50 unique entities, mostly for-profit
- Similar to OCEDs
  - Same limited set of services offered
  - Few patients arrive by ambulance
  - Tend to have low patient volume per day
- Different from OCEDs
  - Not permitted to bill Medicare
  - Mostly paid by private insurers as out-of-network providers (in Colorado payments were ten times higher than urgent care centers)
  - More recently, some insurers have begun negotiating lower rates
  - Payer mix is more narrowly focused on privately insured patients

# Regulation of Stand-alone EDs

## State law

- Controls facility licensure of OCEDs & IFECs, highly variable
- Most states permit OCEDs, some permit both, one prohibits both

## Medicare statute and regulation

- OCEDs may bill Medicare if deemed provider-based:
  - Financially and clinically integrated with affiliated hospital
  - Located within a 35-mile radius of the affiliated hospital
- Site neutral law: OCEDs exempt from prohibition of off-campus facilities billing higher hospital outpatient payment rates (including ED and non-ED services)
- OCED visits not separately identifiable in Medicare claims

# Growth in stand-alone EDs and the relevance to Medicare

- Rapid growth in stand-alone EDs from 2008 to 2016
  - OCEDs: 97 percent increase
  - IFECs: All were developed during this period
- More stand-alone EDs may begin billing Medicare in the near future
  - 203 IFECs

# More facilities to bill Medicare

- IFECs are affiliating with hospitals
  - Partnering with hospital systems on existing IFECs
  - Building new hospitals near existing IFECs
  - Partnering with hospitals to build new stand-alone EDs
- New permutations of the stand-alone ED model

# Four reasons for the growth of stand-alone EDs

- Stand-alone EDs are a mechanism for hospitals and systems to capture patient market share
- Stand-alone EDs can receive higher payment rates when they bill private insurers as out-of-network providers
- Medicare payment structure gives providers the incentive to serve patients in the higher-paying ED setting
- Site neutral law (prohibiting off-campus facilities from billing at higher hospital outpatient payment rates) does not apply to stand-alone EDs, including the ED and non-ED services provided in these facilities.

# Location of stand-alone EDs

- A few stand-alone EDs are located in areas that have recently had a hospital close or in rural areas
- Many stand-alone EDs are located in urban/suburban areas in close proximity of other EDs, and suburban areas with rapid population growth
- In Texas, Colorado, and Ohio, stand-alone EDs are located in ZIP codes with higher incomes, more privately insured patients, and fewer Medicaid patients (Schuur et al. 2016)
- In Houston and Denver, 60 percent of stand-alone EDs are located in ZIP codes with an average income of $90,000 (MedPAC)

# Stand-alone EDs in Colorado and Maryland served lower acuity patients

## Colorado

- Hospital EDs: 7 of the 10 most common conditions were life-threatening conditions
- Urgent care centers: 0 of the 10 most common conditions were life-threatening conditions
- Stand-alone EDs (9 facilities): 3 of the 10 most common conditions were life-threatening conditions

## Maryland

- Stand-alone EDs (3 facilities): 68 to 80 percent of patients were low-acuity ED patients
- Hospital EDs (3 nearest facilities): 46 to 64 percent were low-acuity patients

# Direction and policy discussion

The Commission may wish to consider:

- CMS could begin tracking OCEDs in Medicare claims data,
- Examining incentives that may be encouraging providers to serve patients in the ED setting, and
- Re-examining the emergency department exemption contained within the site neutral law.

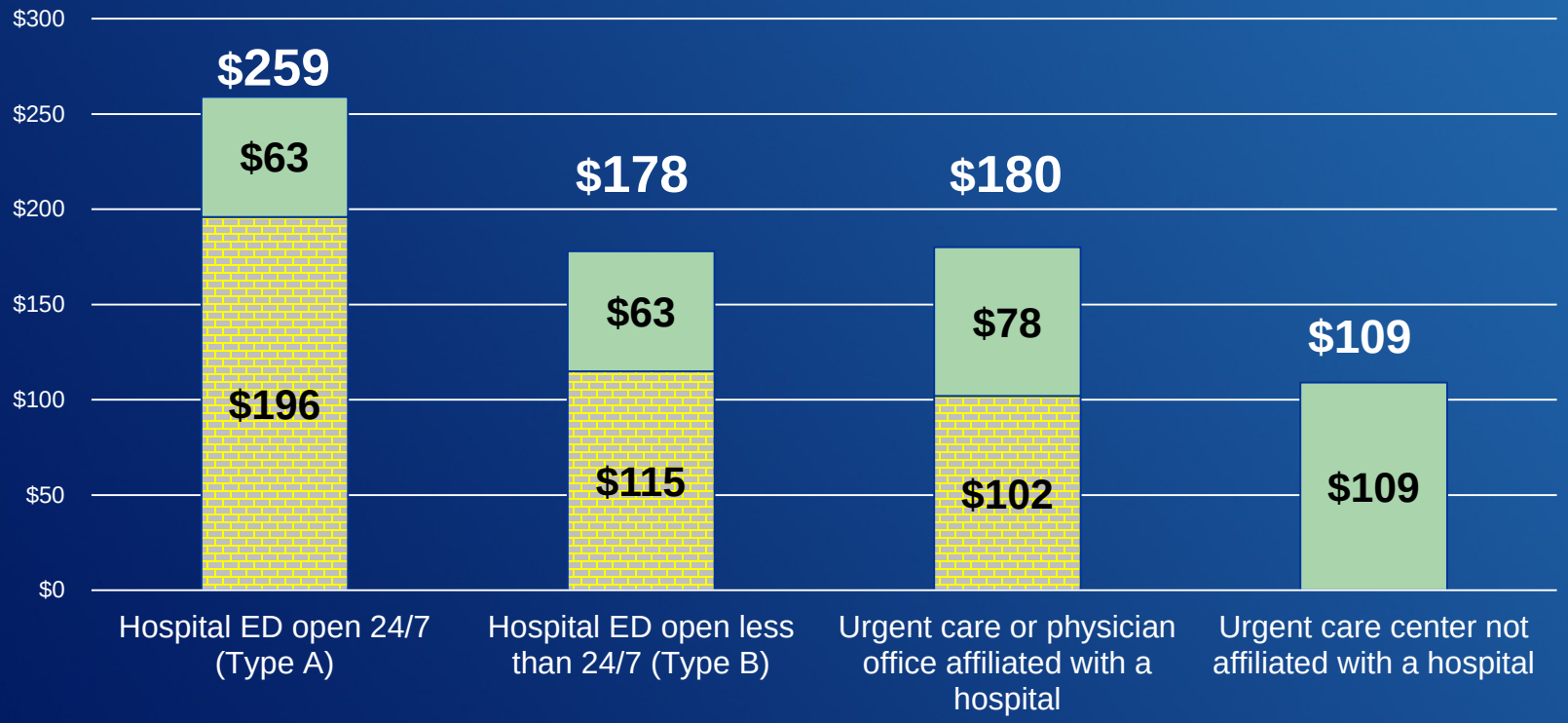
# ED visits grew slightly faster in metropolitan statistical areas (MSA) with stand-alone EDs

| Table 1: Medicare ED volume | OCEDs per million residents | 2010 PFS ED visits per 1,000 FFS enrollee | 2014 PFS ED visits per 1,000 FFS enrollee | Percent change 2010 to 2014 |
|---|---|---|---|---|
| 7 MSAs with the highest OCED concentration (1+ million residents) | 5.4 | 523 | 552 | 5.5% |
| 11 MSAs without stand-alone EDs (1+ million residents | 0.0 | 423 | 425 | 0.4% |

| Table 2: Private insurer volume | Stand-alone EDs per 1 million residents | 2012 ED visits per 1,000 physician users | 2014 ED visits per 1,000 physician users | Change in ED visits per 1,000 physician users (2012-14) |
|---|---|---|---|---|
| 7 MSAs with the highest concentration of stand-alone EDs (1+ million residents) | 11.6 | 182 | 183 | 1.0% |
| 11 MSAs without stand-alone EDs (1+ million residents) | 0.00 | 148 | 146 | -1.3% |

# Shifting low-acuity services to the ED setting

Figure: 2016 payment rates for hypothetical mid-level ED/clinic visit, by type of provider




MEDPAC

# 2016 Medicare emergency department payment rates

| Emergency department level | Physician fee schedule payment amount | Outpatient prospective payment system Type A emergency department visit (24/7) payment amount | Outpatient prospective payment system Type B emergency department visit (less than 24/7) payment amount |
|---|---|---|---|
| **Level 1** | $21.48 | $59.30 | $79.22 |
| **Level 2** | 41.89 | 109.51 | 76.17 |
| **Level 3** | 62.66 | 195.98 | 115.20 |
| **Level 4** | 118.87 | 326.99 | 196.25 |
| **Level 5** | 175.44 | 486.04 | 315.88 |

# ED trauma levels determined by the American College of Surgeons

| Trauma level | Description |
|---|---|
| Level 1 | A comprehensive regional resources that is a tertiary care facility central to the trauma system. Capable of providing total care for every aspect of injury – prevention through rehabilitation. |
| Level 2 | Able to initiate definitive care for all injured patients. |
| Level 3 | Ability to provide prompt assessment, resuscitation, **surgery, intensive care**, and stabilization of injured patients and emergency operations. |
| Level 4 | Demonstrated an ability to provide advances trauma life support prior to **transfer** of patients to a higher level trauma center. Provides evaluation, stabilization, and diagnostic capabilities for injured patients. |
| Level 5 | Provides initial evaluation, stabilization, and diagnostic capabilities and prepares patients for **transfer** to higher levels of care. |

# Overlap in cases served at ED facilities and other competing facilities

| | Hospital EDs | OCEDs | IFECs | Urgent care centers | Physician offices | Retail clinics |
|---|---|---|---|---|---|---|
| Provide ED services? | Yes | Yes | Yes | No | No | No |
| Bill Medicare? | Yes (HOPD & PFS) | Yes (HOPD & PFS) | No | Yes (HOPD & PFS) | Yes (PFS) | Yes (PFS) |
| General severity of cases | Trauma + possible inpatients + low severity | High severity + low severity | | Mostly low severity | | |

Note: ED (emergency department), OCED (off-campus emergency department), IFEC (independent freestanding emergency center), OPPS (outpatient prospective payment system), PFS (physician fee schedule)

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