MEDPAC Medicare Payment Advisory Commission

STATEMENT FOR THE RECORD

# Ensuring access to emergency services for Medicare beneficiaries in rural communities

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Statement of
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Committee on Finance
U.S. Senate


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The Medicare Payment Advisory Commission (MedPAC) is a small congressional support agency established by the Balanced Budget Act of 1997 (P.L. 105–33) to provide independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's goal is to achieve a Medicare program that ensures beneficiary access to high-quality, well-coordinated care; pays health care providers and health plans fairly, rewarding efficiency and quality; and spends taxpayer dollars responsibly. The Commission would like to thank Chairman Hatch and Ranking Member Wyden for the opportunity to submit a statement for the record today.

The Commission has a long history of developing Medicare payment policies to improve access to care, quality of care, and efficiency of care delivery in rural areas. The Commission conducted broad-based reviews of Medicare payment policy in rural areas in our June 2001 and June 2012 reports to the Congress. More recently, the Commission has evaluated causes of rural hospital closures and voted unanimously on a recommendation for a new, voluntary payment option for rural hospitals that would preserve access to emergency services in isolated rural areas. (The recommendation will appear in our forthcoming June 2018 report to the Congress.)

To help ensure beneficiary access to hospital care in rural communities, over time the Medicare program has implemented several adjustments that increase payments to rural hospitals. Many of Medicare's special payments to rural hospitals are linked to inpatient status and are based on hospitals' costs. Despite these special payments, hospital closures have increased in rural areas as populations have declined. The volume of inpatient services provided in small rural hospitals has declined even more rapidly. Though beneficiaries in rural areas where hospitals have closed may be able to receive planned, nonemergent inpatient care from other hospitals, the Commission is concerned that these closures may leave beneficiaries without access to timely emergency care. Given changes in demographics and in the way that care is delivered, Medicare payment policies must change as well. As we outline below, we have recommended a new, voluntary model of payment that will allow stand-alone emergency departments to operate in rural areas that cannot support an inpatient hospital.

## Evaluating access to care in rural areas

Each year, the Commission assesses Medicare beneficiaries' access to health care services. To conduct that assessment, we survey beneficiaries, interview beneficiaries in focus groups, and analyze Medicare data on beneficiaries' use of services. We frequently examine variation in Medicare spending and use of health care services in rural areas across the country, and we visit rural areas with different demographic and practice pattern characteristics. In general, we find that beneficiaries in rural areas use similar levels of hospital services as beneficiaries in urban areas (Medicare Payment Advisory Commission 2017, Medicare Payment Advisory Commission 2012). More broadly, beneficiaries in rural and urban areas also report similar levels of satisfaction with their access to routine care, even though some rural beneficiaries have to travel outside their area to obtain care. (On average, rural beneficiaries travel farther for routine care and obtain about 30 percent of their routine care in urban areas (Medicare Payment Advisory Commission 2012).)

However, while, on average, rural and urban beneficiaries use similar levels of health care services and express comparable satisfaction with their care, there are beneficiaries in some rural communities who may have difficulty accessing emergency care. When a hospital that serves an isolated community closes, even though beneficiaries may be able to travel and receive their nonemergent, planned hospital care in other locations, the Commission is concerned that beneficiaries may not be able to access emergency care in a timely fashion.

The recent increase in small rural hospital closures has underlined the Commission's concern. Fifty-one rural hospitals closed between 2013 and 2017 (Young 2018).[1] Among those closures were 22 critical access hospitals. While 28 of the hospitals that closed were located less than 20 miles from the nearest hospital (suggesting that there may have been excess capacity in these markets and that beneficiaries have alternative sources of hospital care), 21 of the closed hospitals were located between 20 miles and 35 miles from the nearest hospital, and 2 were over 35 miles from the next nearest hospital.

[1] We generally define *rural* as all areas outside of metropolitan statistical areas (MSAs). This definition of rural includes micropolitan areas. Others have a broader definition of rural areas that includes some small towns within MSAs.

## Medicare's special payments to rural hospitals are not targeted to preserve access to emergency services

In addition to evaluating beneficiary access to care, the Commission also examines the adequacy of Medicare payments to providers. In general, our analyses have found that the adequacy of fee-for-service (FFS) payments to rural hospitals does not differ systematically or significantly from the adequacy of urban hospitals' payments. However, the financial performance of rural hospitals varies, and some of the smallest rural hospitals have had the most financial trouble, potentially creating problems for beneficiary access to hospital care.

To support beneficiary access to hospital care, over time the Medicare program has implemented several adjustments that increase hospital payments. For example:

- **Sole community hospital (SCH)—**SCHs are hospitals that are at least 35 miles from the nearest hospital that is paid under Medicare's inpatient prospective payment system (IPPS). More than 300 hospitals are eligible for this program. Payments to SCHs for inpatient services are based on the SCH's historical costs, updated for inflation. This program increased payments to participating hospitals by about $1 billion in 2015, relative to the IPPS rates that would have otherwise applied.

- **Medicare-dependent hospital (MDH)—**MDHs are hospitals with high shares of Medicare patients (60 percent of days or discharges). About 150 hospitals are eligible. In this program, hospitals receive an increase to their inpatient payments that is based 75 percent on the MDH's costs and 25 percent on IPPS rates. Medicare payments to MDHs were about $100 million higher in 2015 than they would have been under the IPPS.

- **Critical access hospital (CAH)—**CAHs are small rural hospitals with 25 or fewer acute care beds. About 1,300 hospitals are designated as CAHs. Each is paid 101 percent of its Medicare costs for inpatient, outpatient, and laboratory services, as well as post-acute skilled nursing care in the hospital's swing beds (acute care beds that can be used for post-acute nursing care). New CAHs must be 35 miles from other hospitals, but many older CAHs were exempted from the distance requirement. The

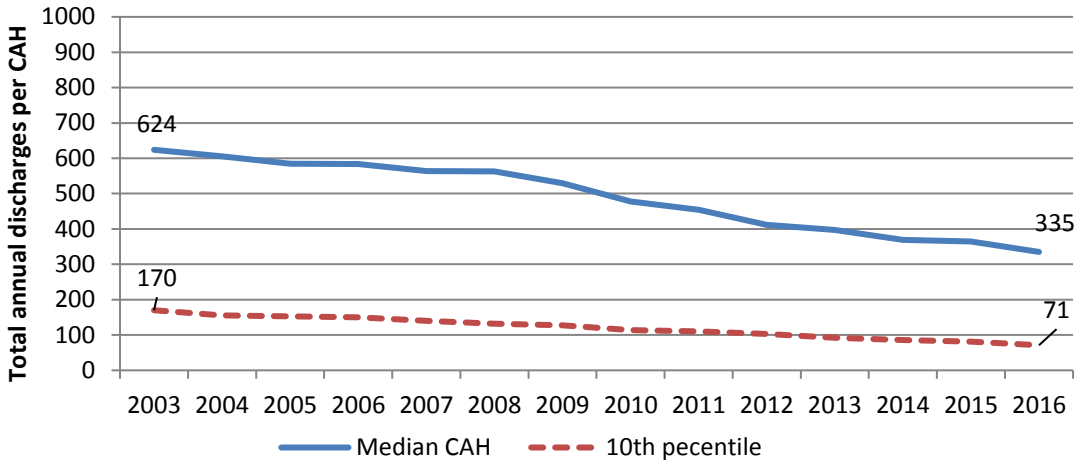
program increased payments to CAHs by about $1 billion in 2015 relative to IPPS rates; because of the way beneficiary coinsurance is calculated for CAH services, the program also increased beneficiary cost sharing by about $1 billion.

In some communities, these special payment policies have not preserved access to high-quality, efficient care for two reasons: (1) these special payments require hospitals to maintain inpatient status, and (2) these special payments are linked to hospitals' costs.

The dilemma is that, for many rural communities, an expensive inpatient delivery model may not be a financially viable option but, to receive these special payments from Medicare, a hospital must maintain its inpatient status and all of the associated costs (e.g., complying with certain staffing and facility requirements). This dilemma has become more acute because the volume of inpatient admissions in rural hospitals has continued to decline.

For example, in 2016, the median number of inpatient admissions (all payers) at CAHs reached fewer than one per day (Figure 1). (In that same year, about 10 percent of CAHs had fewer than two admissions per week.) Declining inpatient volume has important consequences for a rural hospital's financial viability. As the number of admissions falls, the hospital has fewer inpatients over whom to spread its fixed costs. Thus, the cost per admission increases, undermining the efficient delivery of care. In addition, Medicare's special payments to rural hospitals are linked to inpatient volume, so a hospital's special payments fall as volume declines. The drop in inpatient volume has thus contributed to hospital closures.

**Figure 1. Declining inpatient use of critical access hospitals, 2003 to 2016**




Source: MedPAC analysis of hospital cost report data from CMS.

While the use of inpatient services in these hospitals has fallen, in some communities the hospitals may still be needed as a source of emergency care. However, under current policy, isolated communities that want an emergency department (ED) must maintain a hospital with inpatient capacity, even if the hospital does not admit enough patients to be financially viable. This requirement can result in some hospitals offering services (e.g., post-acute services, MRI services) to increase their volume, even though the hospital may not be a relatively efficient provider of that care.

The second reason why Medicare's special payments are poorly targeted to maintain access to care is that payment is based on a hospitals' costs. Thus, these policies provide little incentive for hospitals to manage their costs, resulting in higher spending for the Medicare program and for beneficiaries. In addition, cost-based payment is poorly targeted because it focuses subsidies on a hospitals' historical costs, rather than the access needs of beneficiaries in isolated communities. The challenge for Medicare is to develop payment policies that ensure access to efficient emergency care in rural communities where it is not financially viable to support a costly inpatient facility, while also protecting the taxpayer and beneficiary dollars used to finance the program.

## The Commission's recommendation for a new payment option for rural communities to maintain access to emergency services

In our June 2012 report to the Congress, the Commission set out three principles for designing special payments to preserve access to care in rural areas:

- ***Payments should be targeted toward low-volume isolated providers—that is, providers that have low patient volume and are at a distance from other providers.***
- ***The magnitude of special rural payment adjustments should be empirically justified. That is, the payments should increase to the extent that factors beyond the providers' control increase their costs.***
- ***Rural payment adjustments should be designed in ways that encourage cost control on the part of providers.***

With these principles in mind, the Commission has recommended a new approach for Medicare payment that would give communities options in choosing how best to maintain access to needed emergency care. Importantly, this approach would better target Medicare's subsidies and would not require a significant increase in federal spending. As an alternative to maintaining a costly inpatient-centered hospital, the Commission recommends a new, voluntary payment model that would allow Medicare to pay for emergency services at stand-alone EDs in isolated rural areas (more than 35 miles from another ED). The rural facility would have an ED that is open 24 hours a day and seven days a week, but it would not provide acute inpatient care. The facility could retain other services such as ambulance services and outpatient clinics. We refer to the combination of the stand-alone ED and its affiliated outpatient services as an outpatient-only hospital. Isolated rural full-service hospitals that choose to convert to outpatient-only hospitals would receive the same standard Medicare outpatient prospective payment rates for ED visits as a full-service hospital. (While the Commission's work has focused on the conversion of existing inpatient-centered facilities to this new model of care, new outpatient-only hospitals could also participate in the program to provide access to needed emergency services in communities that do not currently have access.)

In addition, to help cover facilities' fixed costs, Medicare would make a set annual payment that would be the same across all outpatient-only hospitals. Unlike the current cost-based special payments, hospitals with higher cost structures would not receive a higher payment. In addition, the fixed payment would be the same regardless of ED volume, so as not to encourage unnecessary ED use.

If an inpatient hospital chooses to convert to an outpatient-only hospital, we expect that the financing and delivery of care would change as follows:

- Isolated rural hospitals choosing to forgo acute inpatient services would qualify to receive an annual fixed payment from Medicare. The hospital would have discretion on how to use that fixed payment, enabling the hospital to support the costs of operating an ED, so that beneficiaries in that community would maintain access to emergency services. Medicare would pay for emergency services in the outpatient-only hospital under the outpatient PPS.

- Shifting from CAH cost-based rates for outpatient services to outpatient PPS rates would lower beneficiary cost sharing dramatically. The Commission estimates that Medicare beneficiaries could see their coinsurance fall by 70 percent or more. This is because beneficiaries' coinsurance at CAHs is set at 20 percent of charges, which is often close to the full payment amount that Medicare would otherwise make under the outpatient PPS (Medicare Payment Advisory Commission 2016, Medicare Payment Advisory Commission 2011).

- Beneficiary access to scheduled, nonemergent inpatient services would be preserved as patients would be redirected to neighboring hospitals.

- Eliminating services that can be more efficiently delivered in centralized regional facilities (e.g., MRI services) would substantially lower costs relative to existing models.

- Some hospitals might choose to convert their inpatient beds to skilled nursing facility (SNF) beds. SNF PPS rates would be applied to the SNF services provided under the existing eligibility rules.

- Any existing outpatient clinics would continue to operate unaffected by the change in the hospital's status.

### The Commission's recommendation to the Congress

**The Congress should:**

- **allow isolated rural stand-alone emergency departments (more than 35 miles from another emergency department) to bill standard outpatient prospective payment system facility fees and**

- **provide such emergency departments with annual payments to assist with fixed costs.**

This new voluntary payment option would give rural providers greater flexibility to maintain needed access to emergency services in communities that cannot support a full-service hospital. Hospitals would retain the option to convert back to their prior status. Medicare beneficiaries would benefit from local access to emergency services and reduced coinsurance.

The payment option would also preserve access to needed emergency services without a significant increase in Medicare spending. The policy would target existing Medicare payments and replace the cost-based programs that have not preserved access to high-quality, efficient care in some isolated rural communities.

*Note: This recommendation will appear in the forthcoming June 2018 report to the Congress.*

## Outpatient-only hospitals could switch back to prior status

In determining whether or not to participate in the rural outpatient-only hospital model, existing hospital boards would have to decide whether they are willing to discontinue providing inpatient services and convert to outpatient-only hospitals to best meet the needs of their communities. Discontinuing inpatient services would be a difficult decision for rural

communities that have long been served by hospitals that focused on inpatient care. To reduce the communities' perceived risk of losing a full-service inpatient hospital, Medicare could allow all small rural hospitals that convert to outpatient-only hospitals the option of converting back to their prior status in the future if the community determines that such a change is necessary. While we expect this option of converting back to prior status would be rarely used, allowing this option should make it easier for hospital boards to make the initial decision to convert to an outpatient-only hospital.

An outpatient-only hospital would also have the option of aligning with its area's larger hospital system to support some functions at the outpatient-only hospital. For example, the larger hospital system could help with peer review of physicians, purchasing supplies, and billing for services. Under this option, the new outpatient-only hospital could work cooperatively with other healthcare providers to ensure continuity of care across settings.

It is not clear how many providers would choose to convert from an IPPS hospital or CAH status to an outpatient-only hospital under this policy. The decision would in part be determined by the size of the fixed payment and how the program was targeted. The fixed-payment model we discuss is targeted to isolated providers only; *isolated* could be defined as a certain driving distance from other EDs. We use the 35-mile criterion because under current Medicare regulations, EDs can bill Medicare for emergency services if they are affiliated with a hospital that is within 35 miles. Thus, communities within 35 miles of another hospital already have an existing payment method that would support an ED to ensure access to emergency care. In addition, the 35-mile criterion is the limit currently used in the SCH and CAH programs.

## Summary

Maintaining emergency access in rural areas is challenging because of declining populations in many rural areas, coupled with a payment system that is tied to an expensive inpatient delivery model and hospitals' costs. Creating a voluntary payment model to support outpatient-only hospitals in isolated rural communities will help those areas maintain the capacity to provide emergency services, ensuring beneficiary access to necessary services. The Commission's recommendation would provide an annual fixed payment to support the

costs of operating an ED and would allow qualified outpatient-only hospitals to receive outpatient PPS payment rates. This policy would also reduce cost sharing for rural beneficiaries dramatically.

The Commission has long recognized the unique challenges with access to care facing rural Medicare beneficiaries and has continuously supported the development of targeted payment policies to ensure appropriate access while protecting the taxpayers and beneficiaries whose dollars finance the program. The Commission looks forward to continuing to be a resource for the Committee as it develops its policies to achieve the goal of ensuring access to efficient, high-quality care for rural beneficiaries.

## References

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