Using payment to ensure appropriate access to and use of hospital emergency department services

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Outline of today's presentation

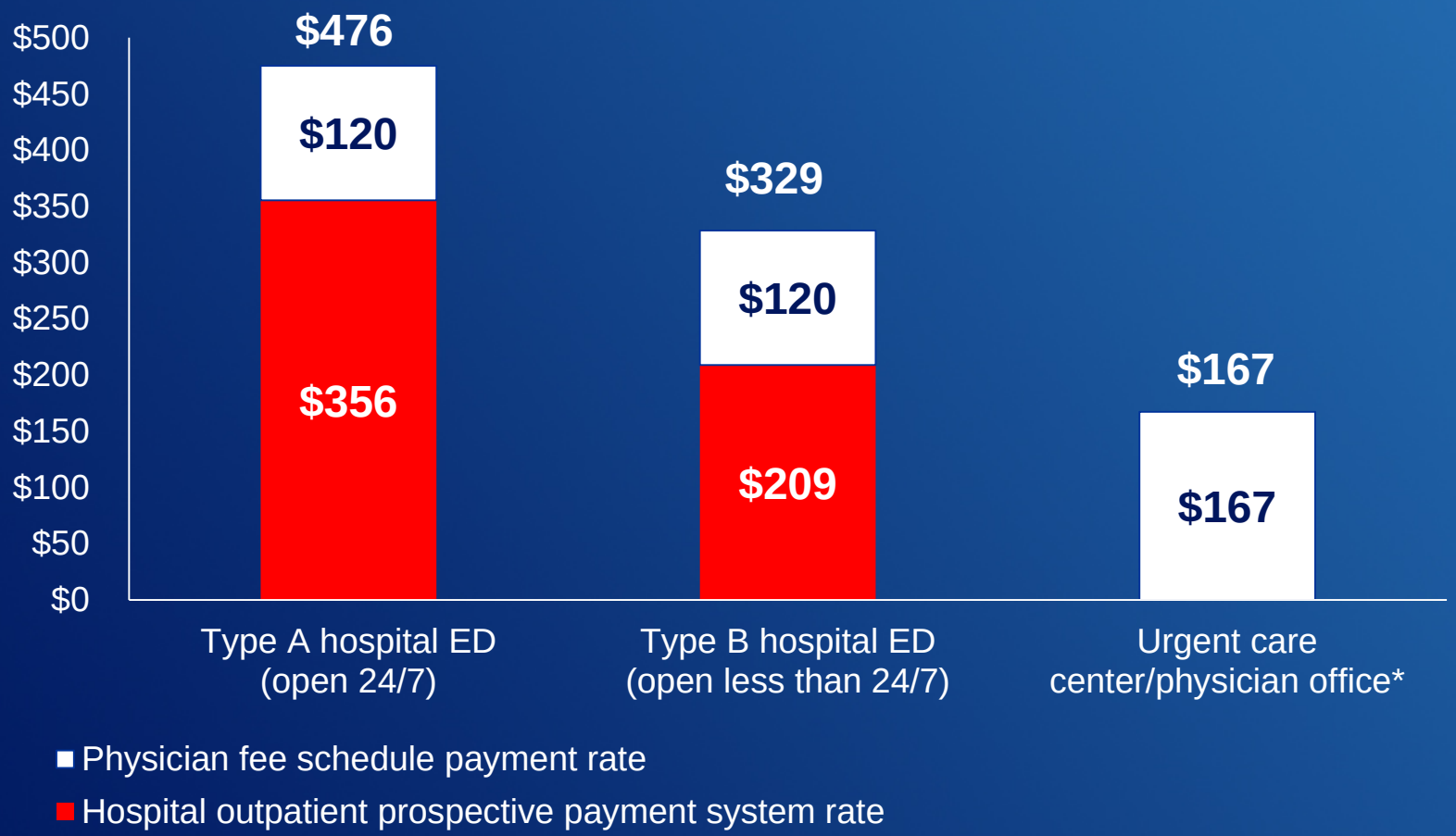
- Review emergency department (ED) use and the ED payment system
- Background on stand-alone EDs
- Rural ED access concerns and policy
- Urban stand-alone ED concerns and policy
- Discussion

Trends in emergency department use and payment from 2010 to 2016

- Medicare outpatient ED use grew faster (14%) than nationwide ED use (7%) and Medicare physician visits (4%)
- The two highest-paying levels of ED visits (levels 4 and 5) represent a growing share of all Medicare ED visits (10 percentage point increase)
- Medicare ED facility fees per beneficiary increased from $79 in 2010 to $136 in 2016 (72% increase)

Results are preliminary and subject to change.

Medicare payment for ED and urgent care center services (2018)



Note: The physician fee schedule (PFS) payment rates for services delivered in hospital EDs reflect level 4 physician ED services, and payment rates for services delivered in urgent care centers and physician offices reflect level 4 evaluation and management codes for new patients.

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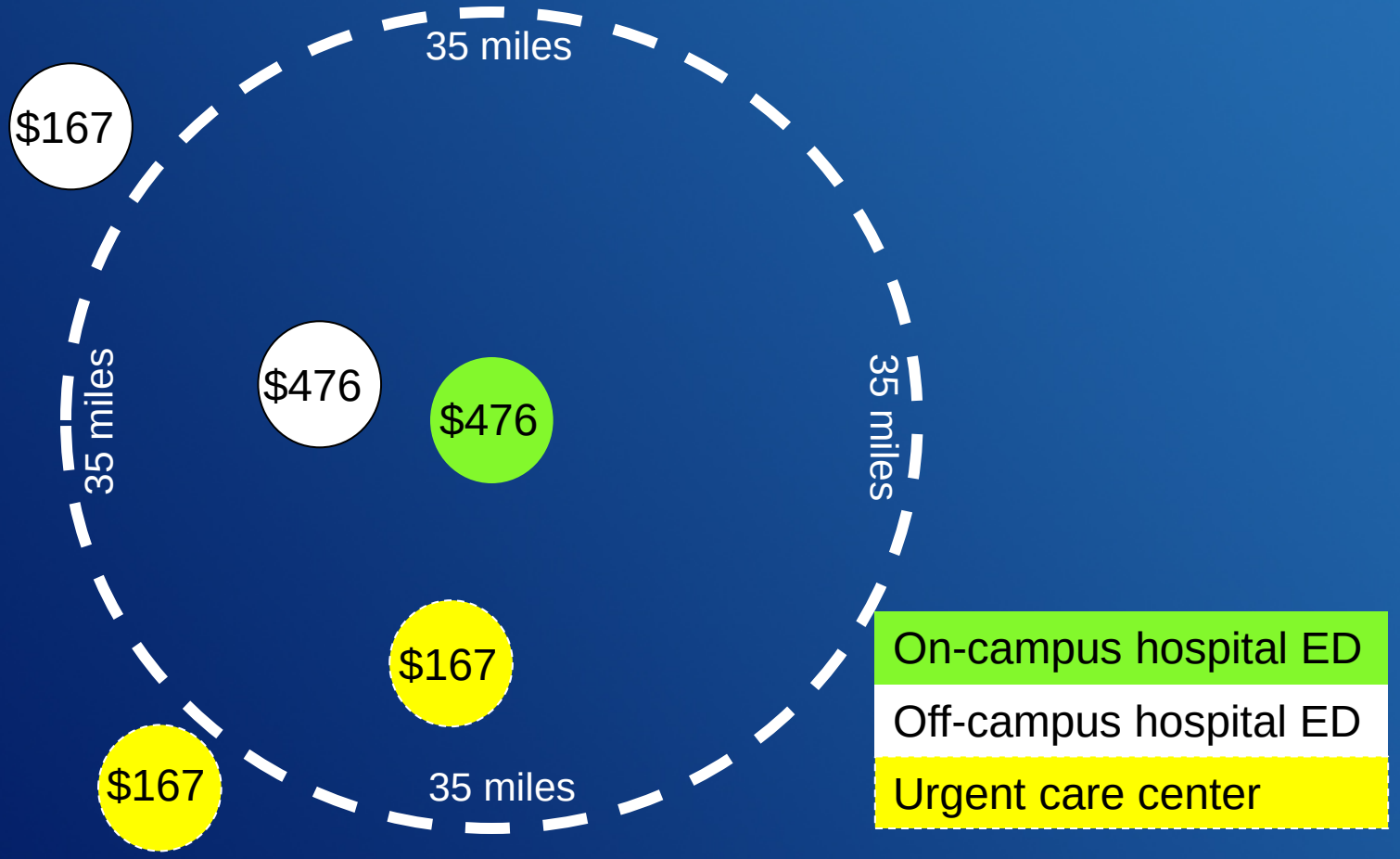
Stand-alone EDs, 2017

- Approximately 550-600 stand-alone EDs
  - Hospital-owned off-campus EDs (OCEDs): 2/3 of all stand-alone EDs
  - Independent freestanding emergency centers: 1/3 of all stand-alone EDs
- Only OCEDs can bill Medicare (if deemed off-campus provider-based departments)

Illustrative example of Medicare ED payments by facility type and geography

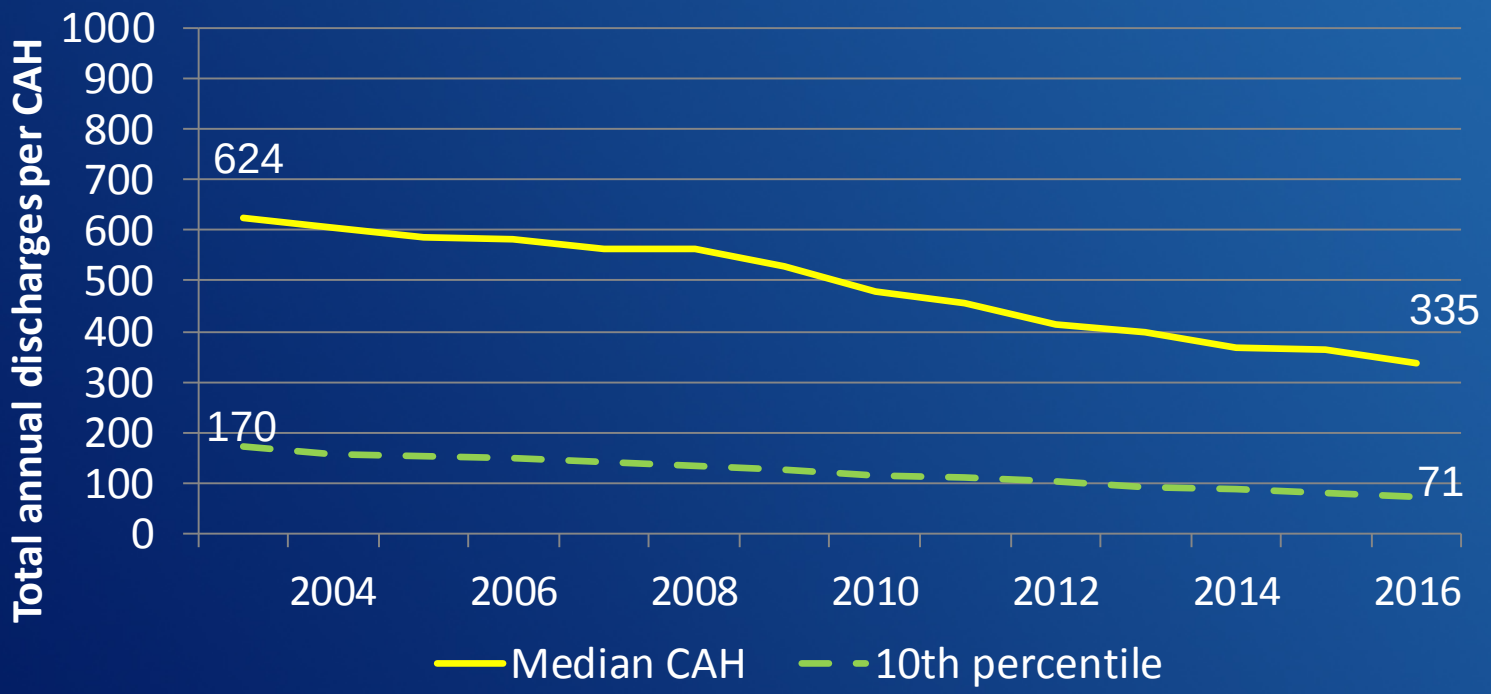


Note: The ED payment amounts displayed are for level 4 Type A ED visits and for level 4 office visits at an urgent care center.

Inpatient-focused rural payment policies are increasingly ineffective

- 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 emergency access

Declining admissions at Critical Access Hospitals



Source: All-payer discharges reported by hospitals on Medicare cost reports.
Results are preliminary and subject to change

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

- Focus on isolated hospitals (e.g., 35 miles from other hospitals)
- Payment
  - Outpatient PPS rates per service, including Type A rates for ED services
  - Medicare fixed subsidy to help fund:
    - Standby costs
    - Emergency services
    - Physician recruitment

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

Urban stand-alone EDs: Concerns

- The number of stand-alone EDs is growing in several urban markets
- Tend to locate in high-income areas
- Majority are in close proximity to on-campus EDs

	Distance to the nearest on-campus hospital ED (miles)				
	0 to 2	2 to 4	4 to 6	6 to 8	8 or more
Cumulative percent	21%	52%	75%	87%	100%
Average minutes to nearest on-campus hospital ED	4.4	8.4	10.3	14.0	18.4

Source: MedPAC analysis of stand-alone ED locations using ARC GIS and google mapping.
Note: Data are for 112 stand-alone EDs in five US markets (Charlotte, Cincinnati, Dallas, Denver, Jacksonville).

Urban stand-alone EDs: Medicare is encouraging overuse of ED services

Urban stand-alone EDs:

- Appear to have lower patient severity (and resource use needs) than on-campus EDs
- Have lower standby costs than on-campus EDs

However,

- Off-campus EDs are still paid the same as on-campus Eds

Rationale for urban OCED policy options

- Better align payments with the costs of care
- Reduce incentives to build new EDs near existing sources of emergency care
- Preserve access to ED services where they are truly needed