

CHAPTER

2

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

R E C O M M E N D A T I O N S

2-1 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.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

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2-2 The Congress should reduce Type A emergency department payment rates by 30 percent for off-campus stand-alone emergency departments that are within six miles of an on-campus hospital emergency department.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

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

Chapter summary

Medicare’s payment policies should foster adequate access to care and encourage efficient delivery of services. Maintaining access to emergency department (ED) services can be a challenge in isolated rural areas, where a single hospital may be the sole source of ED care. If that sole hospital closes, access to emergency care can be lost. In contrast, efficiency can be a challenge in urban areas, where EDs can be in oversupply. New urban stand-alone EDs (medical facilities providing ED services that are located apart from a hospital campus and can be either affiliated or unaffiliated with a hospital) could result in cases shifting from lower cost settings such as urgent care centers and physician offices, which do not provide ED services and are generally not open 24 hours per day, to the higher cost ED setting, which is generally open 24 hours per day. New stand-alone EDs could also siphon off lower acuity (less severely ill) patients from on-campus hospital-based EDs. In this chapter, we recommend two ways to change the way Medicare pays for ED services to reduce the risk of ED services being undersupplied in rural areas and oversupplied in urban areas. Medicare payment rates to isolated rural stand-alone EDs would increase, and payment rates to urban stand-alone EDs close to other sources of emergency care would decrease.

We first review basic information on how Medicare pays for emergency services in rural and urban areas. Second, we outline concerns regarding preserving access to ED services in rural areas, which is a continuation of our

In this chapter

- Background
- Rural areas: Maintaining access to emergency department services
- Urban areas: Incentives have led to an abundance of urban stand-alone EDs
- Future analyses

2016 discussion of rural EDs (Medicare Payment Advisory Commission 2016a). Third, we discuss limiting excess volume of ED services in urban areas, which is an extension of our 2017 discussion of stand-alone urban EDs (Medicare Payment Advisory Commission 2017).

Maintaining access to emergency department services in rural areas

Maintaining access to ED services can be challenging in isolated rural areas with low population densities. In many isolated rural areas, inpatient hospitals' volumes have fallen dramatically, with many hospitals admitting fewer than one patient per day. However, Medicare will pay a facility for emergency services only if it maintains inpatient services. Therefore, small isolated communities that want an ED must maintain a low-occupancy inpatient department in the hospital. In 2016, approximately 130 hospitals averaged less than 1 admission per day (all payers) and were more than 35 miles from other hospitals. EDs at these hospitals serve as important sources of emergency care, but to maintain these isolated EDs, hospitals must maintain their largely empty inpatient beds.

As an alternative to maintaining empty inpatient beds, the Commission is recommending a new 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, 7 days a week, but would not provide acute inpatient care. The facility could retain other services such as ambulance services and outpatient clinics, and 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 prospective payment rates for ED visits as a full-service hospital. In addition, a set annual payment (common across all outpatient-only hospitals) would be made to help cover the facility's fixed costs.

The new payment option would allow rural communities that cannot support a full-service hospital a way to maintain access to emergency care in their community, while retaining the option to convert back to a full-service hospital if circumstances change. The recommendation would increase Medicare spending by less than \$50 million per year.

Encouraging efficient delivery of emergency services in urban areas

Urban hospitals can set up stand-alone EDs that bill Medicare as if they are a part of the hospital's main ED as long as they are located within 35 miles of the main hospital campus. We refer to these hospital-affiliated facilities as off-campus EDs (OCEDs). The number of OCEDs has increased rapidly in recent years, particularly

in areas with high household incomes. ED visits overall and their coded severity levels have increased. Under Medicare's payment system for ED visits, providers have incentives to add new OCEDs rather than urgent care centers, which are paid less than half the hospital ED rates.

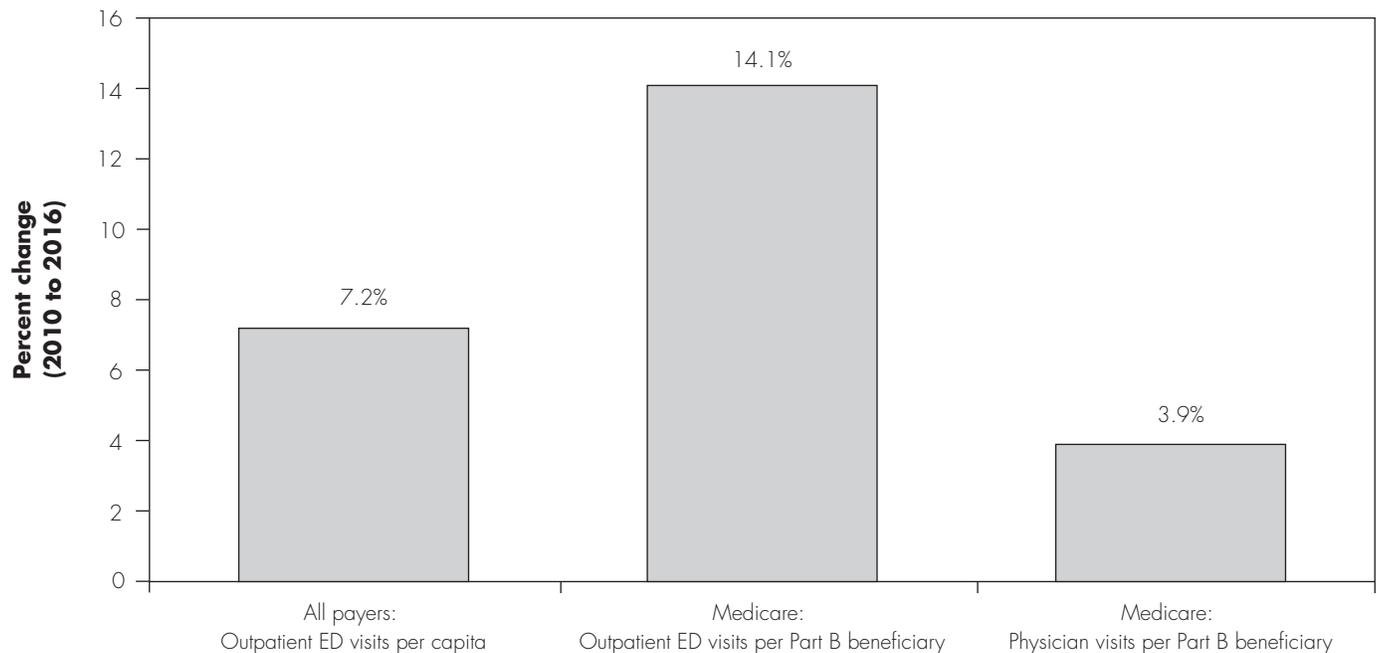
Patients who are served at off-campus EDs appear to have less complex care needs than those of patients served at on-campus hospital EDs. Ambulance operators typically take trauma, stroke, and heart attack patients to on-campus hospital EDs, which provide trauma services, operating rooms, and inpatient services. As a result, off-campus EDs do not incur the standby costs of these resource-intensive services. While urban off-campus EDs may provide some services not available at doctors' offices and urgent care centers, we conclude Medicare overpays these facilities relative to what is paid to on-campus hospital EDs for more difficult cases.

Medicare currently has two levels of payments for OCEDs. One is for EDs open 24 hours a day, 7 days a week (Type A payment rates), and the other is for EDs open less than 24 hours a day, 7 days a week (Type B payment rates). Type B ED rates are lower under the rationale that these facilities have lower standby costs. In 2018, Type B payment rates are roughly 30 percent lower than Type A rates. Evidence from three states indicates that urban OCEDs likely have lower standby costs than on-campus hospital EDs. The Commission is therefore recommending that Medicare pay urban OCEDs the Type A payment rates reduced by 30 percent—which would better align payments with standby costs and make off-campus ED rates similar to Type B rates. An exception would be needed for the one-quarter of OCEDs that are located relatively far (more than six miles) from on-campus EDs and that likely provide unique access to ED services for their local community (other exceptions could be contemplated when an urban OCED is essential to retain access—for example, if the OCED is the result of its parent hospital closing). Paying these more isolated urban OCEDs the full Type A payment rates would be justified to ensure continued appropriate access to emergency services.

The Commission's urban recommendation would better align payment with the standby costs of urban OCEDs in close proximity to on-campus hospital EDs, while maintaining higher payment rates for urban OCEDs that are located farther from on-campus EDs and may provide unique access to ED services. Medicare beneficiaries served at OCEDs close to on-campus EDs would have lower cost sharing, and access to ED services would be preserved in areas where it is most needed. Overall, this policy would reduce the incentive to develop new off-campus EDs and would lower Medicare spending by between \$50 million and \$250 million annually. ■

FIGURE 2-1

All-payer and Medicare emergency department visits per capita grew faster than Medicare physician office visits per capita, 2010–2016



Note: ED (emergency department). Outpatient ED visits are those in which the patient was treated in the ED but not admitted to the hospital. ED visits occurring at on-campus hospital EDs and off-campus hospital EDs are both included.

Source: American Hospital Association and Medicare claims data.

Background

Ideally, Medicare payment policies should encourage the appropriate use and efficient delivery of emergency department (ED) services to both rural and urban beneficiaries. Given that ED services can be critically important to supporting the care needs of Medicare beneficiaries, adequate access needs to be maintained in rural and urban areas. In rural areas, the challenge can be to maintain access to a single ED. In contrast, in some urban areas, concern exists about excessive expansion in the number of EDs, which could result in a shift of care from lower cost urgent care centers and physician offices to higher cost EDs. Off-campus EDs (OCEDs)—those EDs located apart from the hospital campus—could then benefit by treating lower cost patients while receiving rates equal to on-campus EDs that treat higher acuity (more severely ill) patients. Private insurers try to manage demand for emergency services by charging higher cost

sharing in EDs and, in some cases, denying payment for services not deemed emergent (Glatter 2017, Livingston 2018). Higher copayments are unlikely to work for fee-for-service (FFS) Medicare given the widespread use of supplemental insurance. In this chapter, we discuss two ways to change the way emergency services are paid. The objectives are to reduce the risk of undersupply in rural areas and oversupply in urban areas.

ED services are most commonly delivered at the roughly 4,500 on-campus hospital EDs that are typically open 24 hours per day, 7 days a week (24/7). However, increasingly, these services are also provided at OCEDs. Between 2010 and 2016, the number of hospital outpatient ED visits (those not resulting in an inpatient hospital stay) nationwide increased by more than 7 percent per capita across all payers (Figure 2-1).¹ Over the same period, Medicare outpatient ED visits per beneficiary increased 14 percent, while Medicare physician office visits per beneficiary increased about 4 percent. Faster

**TABLE
2-1**

Medicare ED visits in the two highest paying levels grew as a share of all Medicare ED visits, 2010–2016

ED payment level	Outpatient ED visits				Change in number of ED visits	Percentage point change in share of ED visits
	2010		2016			
	Number	Share	Number	Share		
Level 1	682,180	4.4%	660,950	3.6%	-21,230	-0.8
Level 2	1,781,920	11.5	1,312,937	7.1	-468,983	-4.4
Level 3	5,103,120	32.8	5,198,704	28.0	95,584	-4.8
Level 4	4,963,920	32.0	6,426,367	34.6	1,462,447	2.6
Level 5	3,004,240	19.3	4,960,439	26.7	1,956,109	7.4
Total	15,535,380	100.0	18,559,397	100.0	3,023,927	0.0

Note: ED (emergency department). ED payment levels are commonly used as a proxy for the severity of patient illness. Level 1 is the lowest paying level, suggesting these are the lowest severity patients. Level 5 is the highest paying level, suggesting these are the highest severity patients. Data include Medicare Type A and Type B ED visits. Outpatient ED visits are those in which the patient was treated in the ED but not admitted to the hospital. ED visits occurring at on-campus hospital EDs and off-campus hospital EDs are both included.

Source: CMS hospital outpatient claims data.

growth at EDs relative to physician office visits suggests some movement of lower severity cases from lower cost physician offices to higher cost ED settings. In 2016, Medicare beneficiaries accounted for 28.4 million ED visits, counting both outpatient ED visits and ED visits that resulted in an inpatient admission (data not shown).

Volume of higher level cases has increased

For payment purposes, Medicare and many other payers require providers to identify ED visits in one of five levels that are based on Current Procedural Terminology (CPT) codes and general descriptions of the service. Between 2010 and 2016, the number of Medicare outpatient ED visits billed at the highest of the five ED levels increased as a share of all Medicare ED visits, climbing from 19.3 percent to 26.7 percent (Table 2-1). By contrast, during the same period, Medicare ED visits coded in the three lowest paying ED levels declined as a share of all Medicare ED visits. For example, as a share of all ED visits, Level 3 ED visits fell from 32.8 percent to 28.0 percent.

Certain factors could account for the more rapid growth of higher level ED services. One possibility is that providers are coding a larger share of ED visits in the higher paying levels, a practice referred to as upcoding. Given the growth in the overall volume of higher level visits (a 2.6 percentage point increase in Level 4 visits and 7.4 percentage point increase in Level 5), it appears that

coding is at least partially responsible for the increased reported severity. Another possibility is that cases formerly admitted to the hospital are now treated on an outpatient basis, increasing the share of higher severity cases. However, the decline in admissions is too small to fully explain the magnitude of the increase in higher level cases seen in EDs. It is unlikely that the growth in higher level ED visits is the result of a real increase in patient severity because the growth in the number of ED visits in Levels 4 and 5 occurred concurrently with growth in total ED visits. That is, the growth in the share of higher intensity visits did not reflect the movement of low-severity cases out of the ED.

Medicare payments for ED services

Medicare beneficiaries who visit EDs generate a physician claim and a hospital outpatient ED claim. Physician claims for ED visits are paid through the Medicare physician fee schedule (PFS). Hospital claims for ED visits that do not result in an inpatient admission are paid through the hospital outpatient prospective payment system (OPPS) or, in the case of ED visits at critical access hospitals (CAHs), under the CAH cost-based payment system.²

The PFS and OPPS both use the five-tiered scale to pay for ED visits. The physician bills Medicare by identifying one of the five ED levels for each case (Table 2-2). The facility

**TABLE
2-2**

Medicare payment rates for ED visits under the Medicare physician fee schedule and hospital outpatient prospective payment system, 2018

ED payment level	Physician fee schedule rate for an OPSS visit	OPSS payment amount	
		Type A (facility open 24 hours per day)	Type B (facility open less than 24 hours per day)
Level 1	\$21.60	\$68.66	\$102.49
Level 2	42.12	124.65	90.82
Level 3	63.00	219.10	157.66
Level 4	119.52	355.53	209.01
Level 5	176.04	520.85	285.88

Note: ED (emergency department), OPSS (outpatient prospective payment system). ED payment levels are commonly used as a proxy for the severity of patient illness. Level 1 is the lowest paying level, suggesting these are the lowest severity patients. Level 5 is the highest paying level, suggesting these are the highest severity patients. The table reflects 2018 Medicare payment rates under the physician fee schedule and OPSS and does not include payments for ancillary services that might be incurred at the time of treatment. ED visits are those in which the patient was treated in the ED but not admitted to the hospital. ED visits occurring at on-campus hospital EDs and off-campus hospital EDs are both included. While Type A rates are on average higher than Type B rates, payment rates for Type B Level 1 ED visits are anomalously higher than Type A Level 1 ED visits.

Source: CMS calendar year 2018 hospital outpatient prospective payment system final rule.

bills under the OPSS, which maintains two sets of rates that depend on the type of facility. Type A rates are used for hospital EDs open 24/7. Type B rates are used for EDs open less than 24/7.³ In 2018, Type B rates are on average roughly 30 percent lower than Type A rates because Type B facilities do not incur the cost of maintaining standby ED staff 24/7. While Type A rates are on average higher than Type B rates, payment rates for Type B Level 1 ED visits are anomalously higher than Type A Level 1 ED visits.⁴ The volume of claims paid under Type B rates is low, accounting for about 1 percent of all Medicare ED claims in 2016.

When a beneficiary visits an ED, the facility bills Medicare for the ED visit and other outpatient services (e.g., imaging and lab services) under the OPSS, and the physician bills Medicare under the PFS. Under a hypothetical example of the most common level billed—a Level 4 ED visit—the Medicare payment rate for a hospital ED open 24/7 is \$356 (not including other outpatient services) and for the physician is \$120, totaling a Medicare payment of \$476 (Figure 2-2, p. 42). If the same patient were treated at a hospital ED open less than 24/7 (that is, a hospital receiving the Type B rate), the Medicare payment to the facility would be \$209 and payment to the physician would be \$120, for a total payment of \$329.

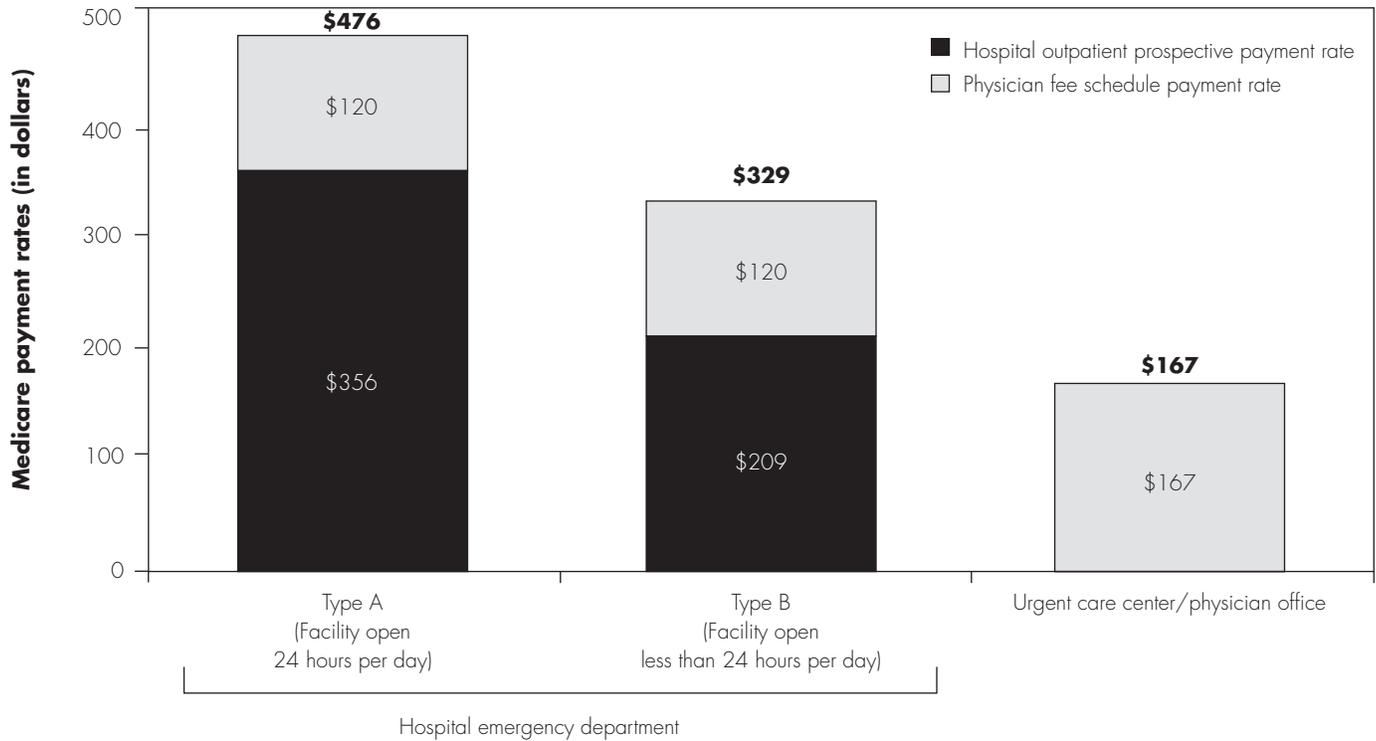
Medicare generally pays lower amounts for services provided at urgent care centers, retail clinics, and physicians’ offices for similar types of patients. New hospital-affiliated urgent care centers, independent urgent care centers, retail clinics, and physician offices are paid the nonfacility PFS rate and are not permitted to bill facility fees for ED services.⁵ Using the same Level 4 example, at one of these non-hospital-affiliated providers, the total Medicare payment would be \$167 to the physician for an evaluation and management (non-ED) visit.

Facilities billing Medicare Type B claims serve lower acuity ED cases

In 2016, about 83 percent of the Medicare Type B claims were in one of the three lowest ED acuity levels (i.e., Levels 1–3; Table 2-3, p. 43). By contrast, only about 38 percent of Type A visits were in one of the three lowest ED acuity levels. This difference may be too large to attribute simply to coding differences at the types of ED facilities and may demonstrate real differences in the acuity of cases treated at Type A and Type B ED facilities. These data suggest that Type B facilities, which in 2016 accounted for 1 percent of all Medicare ED claims, generally serve lower acuity cases than Type A facilities.

FIGURE 2-2

Medicare Type A ED payment rates for similar services are higher than Type B ED payment rates and urgent care centers and physician offices payment rates, 2018



Note: ED (emergency department). Hospital outpatient prospective payment rates for Type A and Type B visits reflect Level 4 ED services. The physician fee schedule payment rates for services delivered in hospital emergency departments reflect Level 4 physician ED services. Payment rates for services delivered in urgent care centers and physician offices reflect Level 4 evaluation and management codes for new patients. In addition, the urgent care center/physician office payment of \$167 reflects the rate paid to new urgent care centers or older urgent care centers not affiliated with a hospital, which do not receive a facility fee for outpatient services. Figures have been rounded.

Source: MedPAC analysis of Medicare 2018 hospital outpatient prospective payment system payment rates and physician fee schedule payment rates.

Current Medicare payment policies encourage stand-alone EDs

A growing number of ED facilities are located apart from a hospital campus and are known as stand-alone EDs. There are two types of stand-alone EDs: hospital-affiliated off-campus emergency departments and independent freestanding emergency centers (IFECs).

OCEDs and IFECs generally offer a similar range of services. Both offer ED services 24/7; basic imaging services such as X-rays, computed tomography (CT) scans, and ultrasound; and on-site lab services for basic diagnostic analyses. Neither typically provides trauma services (e.g., care for victims of car accidents or gunshot wounds). They range in size, with larger facilities serving

as many as 100 patients per day and the smallest facilities serving 20 or fewer patients per day. Larger OCEDs and IFECs also can offer MRI and primary care, house physician specialists’ offices, and tend to take more ambulance transports than smaller OCEDs and IFECs. They typically have one or more physicians on-site at all times (typically under contract). These facilities often advertise that they are open longer (24 hours per day) than urgent care centers and treat medical conditions such as respiratory distress, infection, orthopedic injuries and fractures, and abdominal pain. A certain degree of overlap exists between the lower acuity cases treated at stand-alone EDs and urgent care centers, signifying that urgent care centers are also important in supporting the care needs of Medicare beneficiaries.

**TABLE
2-3**

Medicare Type B ED claims included a larger share of lower level ED visits than Type A ED claims, 2016

ED payment level	Type A ED visits (facility open 24 hours per day)		Type B ED visits (facility open less than 24 hours per day)	
	Number of visits	Share of visits	Number of visits	Share of visits
Level 1	627,561	3.4%	33,389	18.0%
Level 2	1,262,344	6.9	50,593	27.2
Level 3	5,127,832	27.9	70,872	38.1
Level 4	6,400,141	34.9	26,226	14.1
Level 5	4,955,541	27.0	4,808	2.6
Total	18,373,419	100.0	185,888	100.0

Note: ED (emergency department). Total shares of visits may not total 100 percent due to rounding.

Source: CMS hospital outpatient claims data.

Between 2008 and 2016, the number of OCEDs roughly doubled. In 2017, about 580 stand-alone EDs, including OCEDs and IFECs, were in operation. Two-thirds of these facilities—377 facilities—were OCEDs, located in 35 states and affiliated with more than 300 hospitals. The remaining one-third of stand-alone EDs were IFECs. We have identified about 200 IFECs, operating mostly in Texas but also in Colorado and Minnesota. In Texas, the number of IFECs increased from 0 in June 2010 (when state licensure of IFECs began) to 191 facilities in 2016. The proliferation of IFECs between 2013 and 2017 has been particularly rapid in the Dallas metropolitan area, where the number of state-registered IFECs nearly tripled, from 25 to 73.

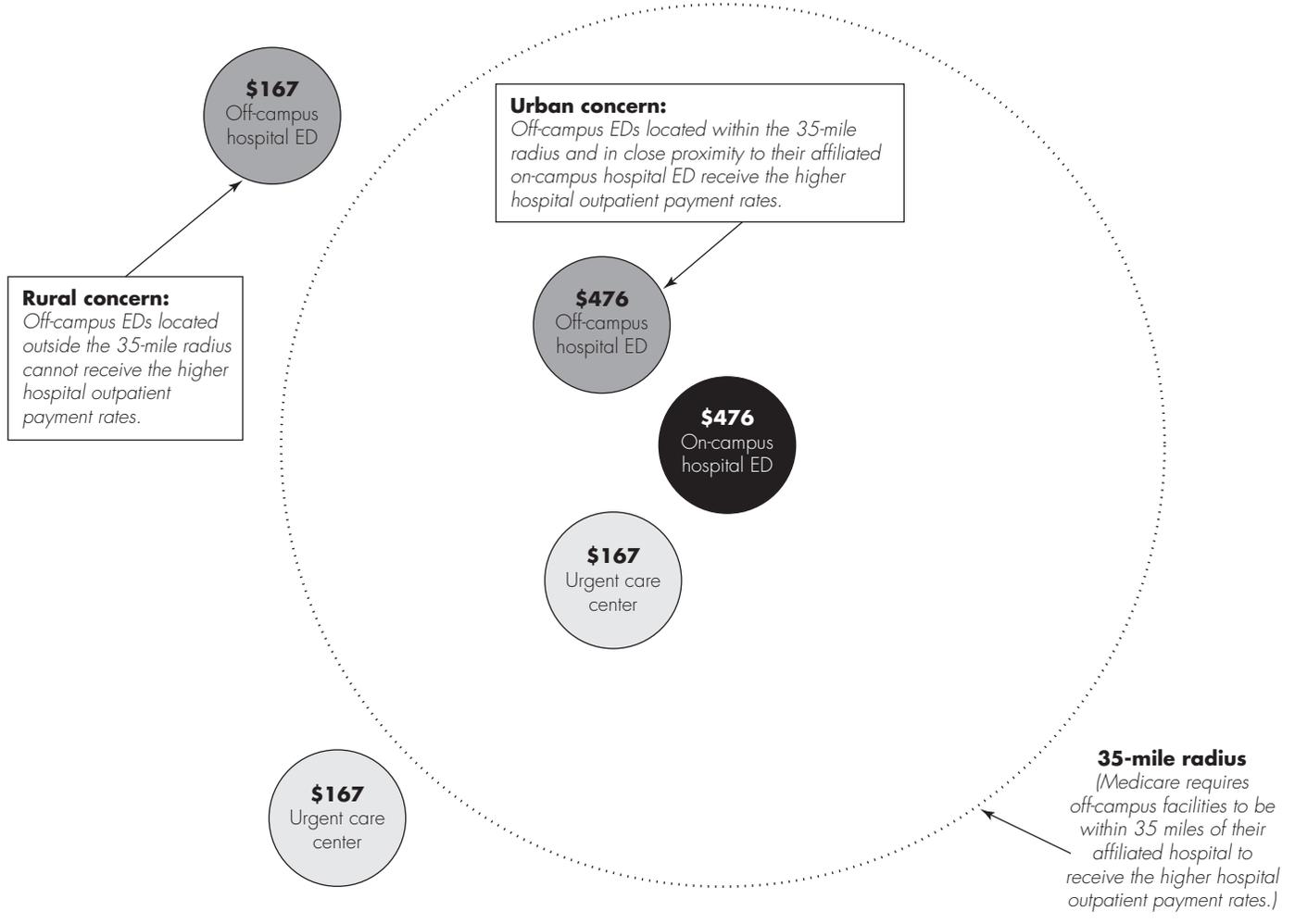
ED services are also provided at micro-hospitals, which are smaller than full-service hospitals and offer a limited range of services. Micro-hospitals focus on the delivery of emergency services and typically have 10 or fewer inpatient beds. Some micro-hospitals also house primary care physician practices, specialty physician practices, and labor and delivery services (Andrews 2016). However, micro-hospitals typically do not offer higher intensity services such as trauma care and intensive care, and patients requiring prolonged care are regularly transferred to larger facilities (Rudavsky 2016). As a result, micro-hospitals likely do not incur the standby costs of full-service hospitals. Nevertheless, micro-hospitals are licensed as independent inpatient hospitals and, as such, can bill Medicare under the OPSS, which pays

substantially more than PFS payment rates. Medicare thus may be overpaying for the ED and outpatient services furnished in micro-hospitals, encouraging their proliferation. About 50 micro-hospitals are open or under development in Arizona, Colorado, Idaho, Missouri, Nevada, Pennsylvania, Oklahoma, and Texas. In addition, the for-profit hospital system Tenet Health stated in its 2018 annual report to shareholders that it currently operates eight micro-hospitals (Morningstar Document Research 2017b). The Commission may conduct future focused research on micro-hospitals.

In addition to EDs, more than 7,000 urgent care centers compete for lower acuity patients.⁶ Urgent care centers provide a broad range of nonemergency services but generally maintain somewhat less service capacity than on-campus hospital EDs. They are typically open less than 24 hours per day; are staffed by physicians, nurses, and physicians’ assistants; and offer relatively limited lab and imaging services. In addition, research suggests that urgent care centers treat lower severity patients than on-campus hospital EDs but that there is overlap between these types of facilities in terms of the types of patients they treat (Baker and Baker 1994, Mehrotra et al. 2009, Thygeson et al. 2008). This overlap occurs among the lowest severity patients. A 2010 study estimated that between 13 percent and 27 percent of cases served in hospitals’ on-campus EDs could be served similarly at urgent care centers or by other providers (Ashwood et al. 2016, Weinick et al. 2010). The severity of patients treated at OCEDs appears

**FIGURE
2-3**

Illustrative example of Medicare ED payment rates by facility type



Note: ED (emergency department). The ED payment amounts displayed are for Level 4 Type A ED visits and for Level 4 office visits at an urgent care center.

to be above that at urgent care centers but lower than that at on-campus hospital EDs. Evaluating how Medicare payment policy influences the treatment location of low-acuity cases at emergency departments may be an area of future Commission research.

Billing for off-campus ED services

OCEDs bill Medicare under the OPPS for a beneficiary's ED visit and any ancillary services (e.g., imaging and lab services), while the clinicians bill under the Medicare PFS. In order to bill Medicare, OCEDs must be deemed off-campus provider-based departments. Provider-based

departments must be in compliance with Medicare and state hospital ED requirements, be financially and clinically integrated with the hospital, be publicized as an affiliate of the hospital, and be located within 35 miles of the main hospital campus (Centers for Medicare & Medicaid Services 2008).⁷ Most private payers pay OCEDs a facility fee and generally consider OCEDs in-network facilities.

If a patient is treated at an OCED, Medicare pays the Type A payment rate as if the patient were at the main hospital campus. As with on-campus EDs, if the patient is transferred from the OCED to the main hospital for

admission, then the ED visit and the ambulance transfer will not be paid separately but, instead, will be deemed part of the cost of the inpatient admission that is bundled into the diagnosis related group payment.

Under current law, hospitals have a financial incentive to build new off-campus EDs and colocate physician offices and specialty clinics within them. The Bipartisan Budget Act of 2015 (BBA of 2015) requires that new “provider-based” clinics owned by hospitals be paid under “the applicable payment system.” The BBA of 2015 did not specify the applicable payment system, but CMS chose a method of paying reduced OPPS rates that are comparable to rates paid in independent physician offices. The BBA of 2015 includes an exception to these reduced OPPS payment rates for any services provided in “dedicated EDs.” This exception, defined in Section 603, requires that both ED and non-ED services (e.g., clinic visits and ancillary services) provided in off-campus EDs be paid the full OPPS payments rates.⁸

The other type of stand-alone ED facility, IFECs, cannot bill Medicare because they are not affiliated with a hospital or considered provider-based facilities by Medicare. Thus, the ED payment policies discussed in this chapter do not address IFECs. Private insurers do not typically contract with IFECs and instead treat them as out-of-network providers. According to several news reports, private insurers are charged significantly higher rates when IFECs are out-of-network facilities, and patients are often left to pay the balance of these charges when claims are denied in part or in full (Rice 2016, Sutherly 2016).

Location of OCEDs can impact Medicare payment rate

Medicare requires provider-based off-campus facilities, such as OCEDs, to be within a 35-mile radius of their affiliated hospitals to receive the higher OPPS payment rates. Figure 2-3 combines the payment rate example used in Figure 2-2 (p. 42) with Medicare’s 35-mile threshold. OCEDs located within a 35-mile radius of their affiliated hospital are paid \$476, the same as an on-campus hospital ED. By contrast, OCEDs located outside of the 35-mile radius are paid \$167 for a comparable service, which is the same as an urgent care center located within or outside the 35-mile radius.

More stand-alone EDs will begin billing Medicare by converting from IFECs to OCEDs

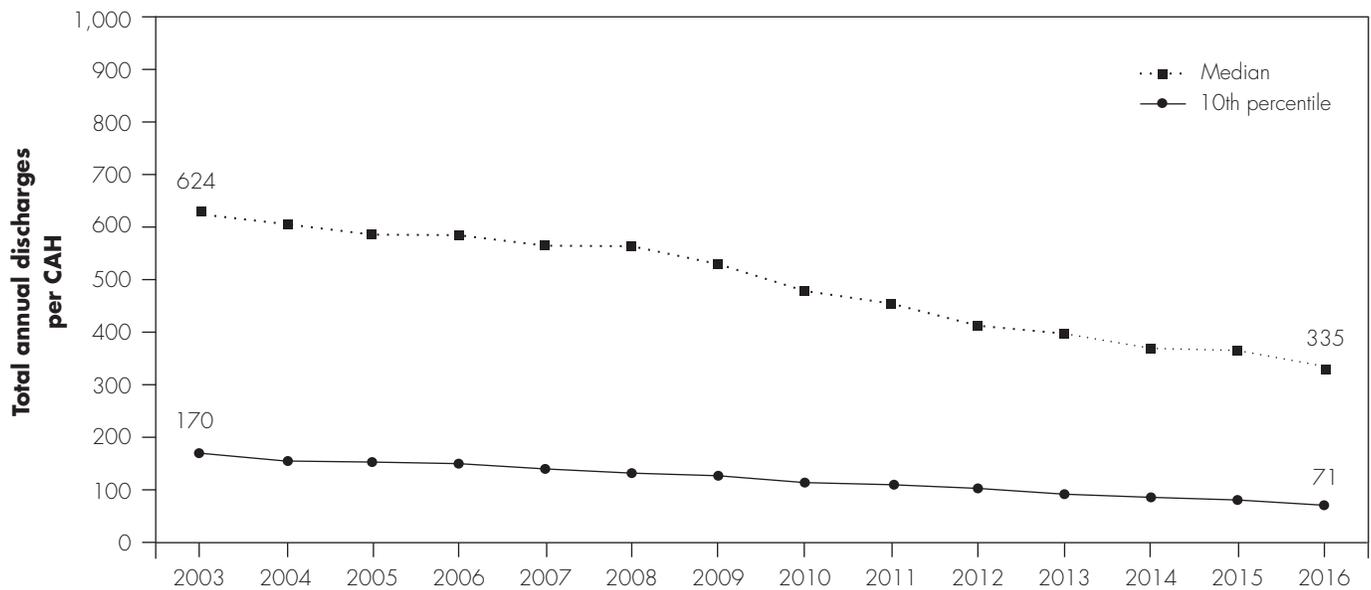
Although Medicare does not pay for services provided in IFECs, many of the 200 IFECs are taking steps to affiliate

with hospitals, effectively converting to new OCEDs, to gain Medicare provider-based status and begin billing Medicare. For example, in recent years, the largest owner of IFECs, Adeptus, modified its business model to partner with hospitals to enable its IFECs to bill Medicare and Medicaid. In Arizona and Ohio, Adeptus partnered with large health systems to build new stand-alone EDs. In Colorado, Adeptus partnered with the University of Colorado Health to build new hospitals with which its existing IFECs could then affiliate. In Texas, Adeptus made two significant changes that enabled their IFECs to begin billing Medicare. First, they began building their own new hospitals (without partnering with a hospital system). Second, Adeptus partnered with hospital system Texas Health Resources, and as a part of the Texas Health Resources agreement, 31 IFECs in Dallas began billing Medicare as OCEDs.

In addition, large for-profit hospital systems are building OCEDs into their business development strategies. In their 2017 annual report to shareholders, Hospital Corporation of America reported that OCEDs are an integral part of their strategy to develop comprehensive health care networks in select communities (Morningstar Document Research 2017a). Community Health Systems also reported that it will use OCEDs to improve market share in certain markets (Community Health Systems 2017). The investment of these large hospital systems in OCEDs suggests the model is viewed as beneficial to the overall success of the system.

Growth in private-payer payment rates also encourages the development of stand-alone EDs

The proliferation of stand-alone EDs is at least in part due to incentives created by commercial insurance contracts to expand ED services. The Health Care Cost Institute reported that the price paid per emergency room visit by private insurers increased by 31 percent from 2012 to 2016 (Health Care Cost Institute 2018). Given the growth in the number of stand-alone EDs during these years, it appears that the providers’ pricing power is sufficient to encourage expansion. Private insurers try to manage demand for emergency services by having higher cost sharing in emergency departments and, in some cases, denying payment for services not deemed emergent. Higher copays are unlikely to work for fee-for-service (FFS) Medicare, given the widespread use of Medicare supplemental insurance. Therefore, other mechanisms for preventing excess use of EDs are needed for the Medicare program.

**FIGURE
2-4****Inpatient use of critical access hospitals declined, 2003–2016**

Note: CAH (critical access hospital).

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

Rural areas: Maintaining access to emergency department services

Maintaining emergency access in rural areas is challenging due to declining populations in many rural areas, coupled with a delivery system that is tied to an expensive inpatient delivery model. In addition, rural hospitals are losing volume as rural patients often bypass their local rural hospital for larger (and more distant) rural or urban facilities. In many cases, the bypass occurs even when the services are available locally (Liu et al. 2008, Medicare Payment Advisory Commission 2012, UnitedHealth Center for Health Reform & Modernization 2011). By 2016, the urban hospital occupancy rate was 66 percent compared with 40 percent for all rural hospitals and 31 percent for rural hospitals with fewer than 50 beds (Medicare Payment Advisory Commission 2018). In 2016, approximately 130 hospitals were more than 35 miles from other hospitals and averaged fewer than 1 admission per day (a map is included in online Appendix 2-B, available at <http://www.medpac.gov>). The question is whether emergency services can be provided by these isolated facilities without having to maintain the hospitals'

inpatient facilities, which are operating at a scale that may not be optimal from a quality or cost-of-care standpoint (Medicare Payment Advisory Commission 2016a).

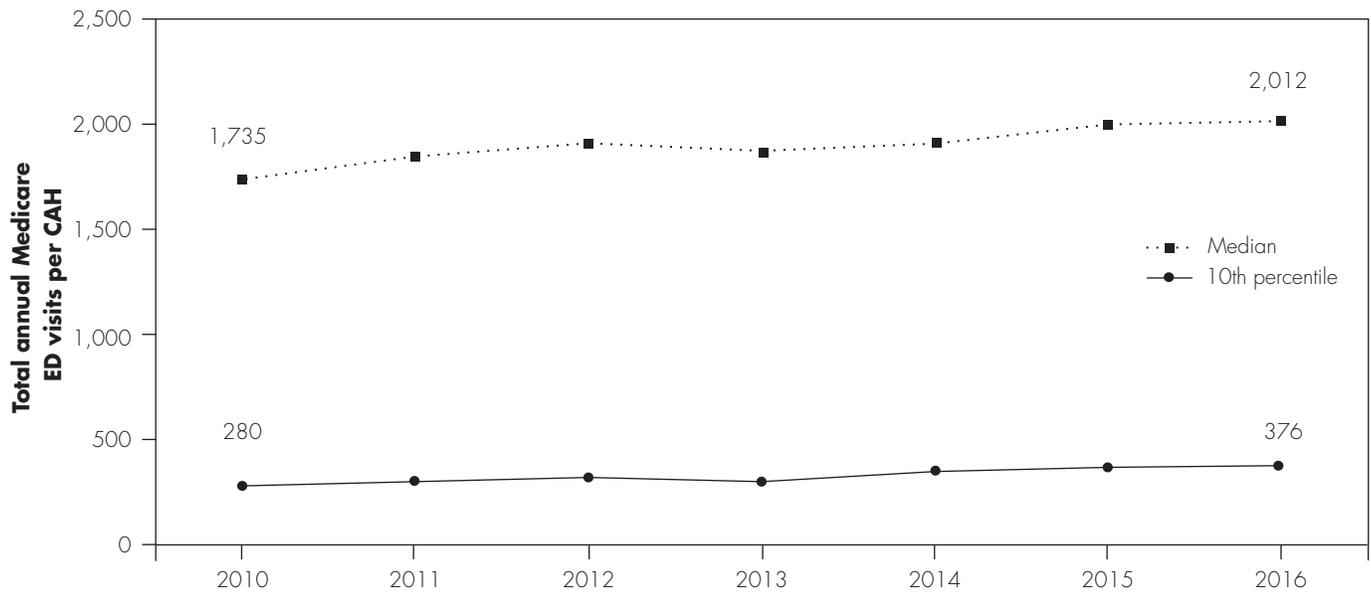
Medicare's existing programs for preserving rural hospitals are inpatient-centric

The Medicare program has several rural payment programs designed to preserve rural hospitals. Most of these programs are inpatient-centric models. The sole community hospital (SCH) program increases inpatient and outpatient payments by about \$900 million per year above inpatient prospective payment system (IPPS) rates to over 300 SCHs. The Medicare-Dependent Hospital (MDH) Program increases inpatient payments by about \$100 million per year above IPPS rates to about 150 rural hospitals. Sixty percent of rural hospitals (1,300) receive cost-based payment through the CAH program. This cost-based payment program increases payments to CAHs by about \$2 billion per year relative to prospective payment system rates for acute care hospitals (Medicare Payment Advisory Commission 2012).

Despite the SCH, MDH, and CAH programs, rural hospital closures have increased in the last three years.

**FIGURE
2-5**

The number of Medicare outpatient emergency department visits at critical access hospitals grew, 2010-2016



Note: ED (emergency department), CAH (critical access hospital).

Source: MedPAC analysis of Medicare outpatient claims data.

Some closures reflect excess capacity, but in other instances, the closed hospitals were the sole providers of emergency services in their area. From 2013 through 2017, 51 rural hospitals closed (67 if we include rural areas of metropolitan counties) (Young 2018).⁹ Among the closures were 22 CAHs. While 28 of the closures were less than 20 miles from the nearest hospital (suggesting there may have been excess capacity in these markets), 21 were 20 to 35 miles from the nearest hospital, and 2 were over 35 miles from the nearest hospital.

The financial challenges faced by CAHs can include declining populations, declining volume of patients with commercial insurance, difficulty recruiting physicians, continued uncompensated care costs, and patients bypassing the local CAH for larger hospitals. In particular, the decline in admissions is difficult for hospitals built on an inpatient payment model. From 2003 to 2016, the median number of annual all-payer discharges among CAHs fell from over 600 to 335, and 10 percent of CAHs had 71 or fewer discharges in 2016 (Figure 2-4). Despite having 25 or fewer beds per CAH, the median CAH

occupancy rate (including post-acute swing-bed patients) between 2006 and 2016 fell from 38 percent to 31 percent.

While hospitals' inpatient volume continues to decline, the use of the emergency services at CAHs increased slightly in recent years (Figure 2-5). This increase suggests the community still values local emergency access. Figure 2-4 and Figure 2-5 together illustrate how CAHs have shifted substantially to outpatient rather than acute inpatient services. In contrast, rural payment models continue to be inpatient-centric.

To maintain access to care in communities where inpatient volume is declining, there is an interest in payment models that are focused on outpatient access rather than maintaining inpatient services (American Hospital Association 2016, Iglehart 2018, Thompson 2015). A key question is whether a rural hospital could cease providing its inpatient services and still generate enough outpatient revenue to maintain an ED. This approach works in some communities, but they are generally rural communities with a fairly high ED volume and payer mixes that

Examples of rural off-campus emergency departments

In August 2017, Commission staff conducted multiple site visits to off-campus emergency departments (OCEDs) located outside of major metropolitan areas. The facilities we visited were located within 35 miles of their parent hospitals and therefore considered OCEDs for the purposes of Medicare billing. The OCEDs were located in communities that experienced hospital closures, often due to low inpatient volumes that led to financial losses; some of the OCEDs were located in the same physical facilities that once housed the closed hospitals. We toured the facilities and spoke with representatives of those facilities, representatives of their parent hospitals, and local emergency medical services (EMS) providers to better understand the challenges associated with operating an OCED in more rural locations and to inform our discussion of potential policy changes.

The representatives with whom we spoke said the cost to run their OCEDs was anywhere from approximately \$3 million to \$5 million a year. Some of these estimates are likely low because they did not include costs such as depreciation or rent and represent efficiencies of belonging to a system. For example, one facility we toured rents its building from the county government for a nominal fee. Its representatives asserted that if the ED had to pay market rates for the building, their costs would be higher. In another instance, the system

to which one OCED belonged centralized many administrative services (e.g., billing, legal services, and contract negotiations) and charged the stand-alone ED a fee. The costs to provide those services would likely have been much higher if the facility had provided them independently. Given these circumstances, the estimates we heard during our site visits were in line with previously published research suggesting a minimum budget of roughly \$5 million per year to operate a rural OCED (Williams et al. 2015).

At each of our site visits, the facility representatives said receiving Medicare's facility payments is critical to ensure the viability of their stand-alone EDs. To demonstrate that point, representatives of the parent hospital of one of the freestanding rural EDs we visited said other struggling inpatient hospitals have contacted them to inquire about converting their facilities to stand-alone EDs. The offers were turned down because none of their own hospitals were within 35 miles of the struggling facilities, which would have made the struggling inpatient hospitals unable to bill as an outpatient department of the larger hospital and receive facility payments from Medicare. The need to receive facility payments for their Medicare patients is particularly acute for rural facilities because more of their patients tend to be covered by Medicare and fewer tend to have private insurance. Some representatives said their stand-alone EDs were not financially viable

(continued next page)

include a large share of privately insured patients. Most conversions of rural hospitals to stand-alone EDs are cases in which the closed hospital is within 35 miles of another hospital and can be deemed an outpatient department of another hospital. That arrangement allows the hospital to obtain facility fees. (See text box for more detail on how this model of rural OCED can work.) In contrast, stand-alone EDs that cannot bill for facility fees are often not financially viable.

Some rural communities have too few ED patients and too few private-pay patients to make the stand-alone

ED model work without additional subsidies. For example, after three rural Georgia hospitals closed, some discussed operating them as stand-alone EDs. However, a committee formed by the state concluded that the stand-alone EDs would not have enough volume to be viable without additional support (Rural Hospital Stabilization Committee 2015). In addition, if a closed hospital is more than 35 miles from another hospital, the hospital cannot operate as a department of another hospital and receive facility fees. This situation is at odds with the objective of preserving access: Isolated communities are the ones that currently cannot receive Medicare's facility fees for

Examples of rural off-campus emergency departments (cont.)

even with Medicare's outpatient prospective payment system Type A ED payment rates and therefore required additional subsidies to remain open. For example, one stand-alone ED initially received a subsidy from the system to which it belonged to remain viable, and one stand-alone ED remained viable only because it was an off-campus department of a critical access hospital that received cost-based reimbursement from Medicare.

The facility representatives said viability also depended on achieving a certain volume of ED visits. They said they generally need 30 to 40 visits per day, or roughly 10,000 to 15,000 visits per year, for a rural off-campus ED to remain sustainable, although they noted that the number of ED visits required to remain viable varies based on factors such as payer mix. For the stand-alone EDs we visited, facility representatives said the vast majority of their patients were walk-ins, as opposed to patients arriving by means of ambulance or helicopter. While representatives said their EDs treat patients with a variety of severity levels—from patients in cardiac arrest to those who need a simple X-ray—they suggested that patients treated at their stand-alone EDs tended to present with less severe injuries or illnesses compared with patients at on-campus EDs.

The EMS providers we interviewed said their staff are familiar with the capabilities of all the local

health care facilities, including stand-alone EDs and hospitals. While patients may request to go to a specific facility, the EMS providers said their staff make recommendations to patients and select the facility for those who are unconscious or otherwise unable to make a decision. For example, the stand-alone EDs we visited were generally bypassed or used only to stabilize patients with ST-elevation myocardial infarctions, a life-threatening type of heart attack during which one of the heart's major arteries is blocked. This dynamic whereby more serious cases routinely bypass stand-alone EDs may be somewhat different for facilities that are farther away from other hospitals because bypassing such facilities means a longer transport than bypassing a stand-alone ED that is located near another hospital. In general, the representatives of systems that operated both rural and urban OCEDs said that patients at rural stand-alone EDs tended to present with more serious injuries or illnesses than those at urban stand-alone EDs because the rural facilities are often a longer distance from other hospitals with an ED than urban stand-alone EDs.

In addition to ED visits, all the facilities we visited had some colocated services and used their equipment for dual purposes. For example, all the facilities we visited rented space to local physicians, including primary care physicians and specialists. Some local residents also used the facilities for nonemergent care, most commonly for imaging and laboratory services.

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OCEDs. These rural facilities may see the only option under current payment policy is to continue as a CAH and receive cost-based payment; however, that is not efficient and may not be financially sustainable.

Extra inpatient payments do not always keep the emergency department doors open

High inpatient payments have not always kept rural hospitals open. In 2016, we conducted an examination of all CAHs that closed in 2014. We found that, before their closure, the seven hospitals received an average of \$500,000 in payments above the comparable prospective

payment system (PPS) payments (Medicare Payment Advisory Commission 2016a). These supplemental payments primarily reflected high rates that CAHs receive for post-acute care.

The extra payments for inpatient care were not sufficient to keep these hospitals open because the extra payments were absorbed by these hospitals' high inpatient costs per day of care. For policymakers, a key question is whether these hospitals could have retained emergency capacity if the Medicare program had directed the supplemental payments toward preserving emergency services rather than subsidizing acute and post-acute inpatient services.

Examples of rural off-campus emergency departments (cont.)

All the EDs we visited offered a range of imaging services, including X-rays, ultrasounds, and computed tomography (CT) scans, and sometimes including additional imaging services such as mammography, nuclear medicine, and magnetic resonance imaging. Because the stand-alone EDs we visited were considered hospital outpatient departments, the facilities received hospital outpatient rates rather than the lower physician office rates for imaging services.

The facility representatives said that rural hospitals traditionally staffed their EDs by relying on community physicians to cover the ED. The use of this model is decreasing because it has become harder to find physicians willing to maintain a community practice plus cover the ED. They said rural EDs are increasingly staffing their EDs with dedicated personnel. All the stand-alone EDs we visited were staffed 24/7 with a physician board-certified in emergency medicine that was contracted through a physician staffing company (e.g., Apollo or EmCare), and some supplemented their physicians with midlevel practitioners during peak hours. Facility representatives said it can be difficult to recruit and retain such personnel to practice in rural areas. They also noted that rural facilities might have to pay such companies subsidies amounting to several hundred thousand dollars per year to recruit physicians to practice in a rural ED. For example, the physician staffing company would receive all the professional billings for the services their physicians perform in the ED plus an additional subsidy from the hospitals. We heard that some rural EDs have faced difficulties financing such subsidies. The representatives noted that

some hospitals were able to avoid paying a subsidy for their ED physicians because the system to which they belonged negotiated a contract for all of the system's EDs, which included urban facilities and facilities with better payer mixes.

Finally, some of the facility representatives said that being part of a larger hospital system was critical to making their stand-alone ED financially viable and more medically capable. According to the representatives, being part of a system helped them decrease costs (e.g., by centralizing nonclinical functions and increasing their purchasing power for drugs and supplies) and increase revenues (e.g., stand-alone EDs benefit from the higher private-payer rates negotiated by the larger system). Clinically, they also mentioned that being part of a system gave their stand-alone EDs better access to physicians by, for instance, allowing the hospital system's employed physicians to rotate through rural areas (e.g., attend a clinic one day a week) and increasing the timeliness of specialist consults through telehealth. All the facilities we visited had some telehealth capabilities. For example, physicians at a more remote stand-alone ED would take a CT scan of a patient who suffered a stroke and project that image on a screen along with a live video of a neurologist who was based at an urban hospital. This approach allowed the ED physician access to the expertise that is often unavailable in rural areas but is critical in determining the appropriate course of treatment, such as whether to administer a clot-busting drug and whether the patient needs to be transported by means of ambulance or helicopter. ■

Limitations on growth of rural OCEDs

To bill as an OCED, a rural ED must be within 35 miles of the main hospital campus. For urban EDs, this requirement is largely not a problem unless a hospital system seeks to open a stand-alone ED in a distant market, but for rural areas, the 35-mile criterion can be a challenge. For example, if a rural hospital wants to set up an ED in a community 10 miles away, it can do so and receive full Type A ED rates. But if the same hospital opened an ED

in response to a closure 40 miles from other hospitals—in a community that truly lacks access to ED services—the hospital setting up that OCED would be paid at physician office rates. The net result is that the Medicare program currently pays more for care in OCEDs that are close to alternative sources of emergency care than it does for EDs that are the only source of ED care. As we discussed in the text box on rural off-campus emergency departments,

these isolated EDs appear to receive more difficult cases than the higher paid OCEDs that are close to a hospital.

A new policy to preserve isolated rural emergency departments

There is a growing interest in trying to preserve access to 24-hour emergency services in rural areas without requiring hospitals to provide inpatient services (American Hospital Association 2016, Iglehart 2018, Morse 2015). Any such policy should achieve three objectives:

- provide a mechanism for preserving emergency access in isolated areas
- not materially increase overall Medicare spending
- improve efficiency of the health care delivery system

Under a proposed rural 24/7 ED model discussed in our June 2016 report, Medicare would pay the Type A outpatient ED rates plus a fixed payment to partially cover overhead services (Medicare Payment Advisory Commission 2016a). This approach would encourage the outpatient facility to focus on ED services, ambulance services, and primary care. The fixed payment could be used to support the rural ED's standby costs and the cost of other services that help preserve access, such as telehealth services. While a few rural PPS hospitals as well as a few rural clinics could convert to a model of an outpatient-only hospital, the providers most likely to convert would be CAHs with very low inpatient volume.

To fund the additional fixed payment without materially increasing overall Medicare spending, Medicare could use the savings generated from discontinuing inpatient payments at the CAHs participating in this model—roughly \$500,000 on average—to fund the fixed payment. A subsidy of this magnitude would represent about 10 percent of the cost of operating a small stand-alone ED.¹⁰ The rationale for this approach is that if standby emergency and primary care capacity are the desired services, then Medicare should subsidize the cost of facilities' standby capacity with an annual fixed payment rather than increased payments per inpatient day. The fixed Medicare payment and the annual local support from the town, hospital district, or county would help maintain emergency access, even in a low-volume environment. See online Appendix 2-A, available at <http://www.medpac.gov>, for a summary of the proposed rural policy.

There may be some rural communities where the population is too low to support a 24/7 ED (even given

the annual subsidy). Our June 2016 report discussed the option of having a clinic open 12 hours a day 365 days a year as an alternative for very low-volume providers (Medicare Payment Advisory Commission 2016a). However, rather than form a new payment model for such facilities, it may make sense for them to be operated as federally qualified health centers (FQHCs). The FQHC program provides federal grant funds and a per visit payment to support stand-alone clinics in rural and urban areas.

All hospitals that convert to an outpatient-only facility would receive equal annual fixed payment amounts. Unlike a cost-based model, hospitals with higher cost structures (often those with more financial resources) would not receive a higher payment. The fixed payment would also not increase with volume because standby ED costs would not materially shift with volume changes, and Medicare would not want to encourage unnecessary ED use. It would also differ from cost-based models because hospitals would no longer have an incentive to offer services for which their costs are not competitive (e.g., post-acute services, MRI services) because additional volume would not lead to increases in supplemental Medicare payments.

If a hospital with inpatient services converted to an outpatient-only facility, we expect that the financing and delivery of care would change as follows:

- Isolated hospitals choosing to eliminate acute inpatient services and accept PPS rates would qualify to receive an annual fixed base payment from Medicare. The inpatient volume would flow to neighboring hospitals, potentially improving the neighboring hospitals' financial viability.
- Given that the fixed payment would be directed to preserving emergency access, some hospitals could convert their hospital beds to skilled nursing facility (SNF) beds for which they would receive SNF PPS rates for the SNF services provided under the existing eligibility rules.
- Converting facilities would make it possible to place a priority on emergency care.
- Outpatient clinics would continue to operate (e.g., FQHCs and freestanding rural health clinics).
- The facilities would have greater flexibility to use telehealth consultations. They would still receive the

hospitals' OPPS telehealth fee, but they could also use the fixed payment to help support telehealth.

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

Rural stand-alone EDs could switch back to CAH status

In determining whether or not to participate in the rural outpatient-only hospital model, existing hospital boards would have to decide whether they were willing to discontinue providing inpatient services and convert to outpatient-only hospitals. Discontinuing inpatient services would be a difficult process for rural communities that have long been served by hospitals that focused on inpatient care. To reduce the communities' perceived risk of conversion, Medicare could allow all CAHs that convert to stand-alone EDs the option of converting back to CAH status in the future if the community demographics change so that a full-service hospital is once again needed in the community. Conversion back to a hospital, although rare, is occurring in one of the communities we visited. As discussed in the text box on rural OCEs (pp. 48–50), we visited three communities where the only hospital within 20 miles closed. In two of the three communities, the population of the town grew fairly rapidly after the hospital closed. In both cases, population growth led to opening stand-alone EDs where two hospitals were once located. In one of the communities, the population has continued to grow to the point where the operator of the ED is now going to build a new full-service hospital attached to the stand-alone ED. While we expect this option of converting back to a CAH will be rarely used, it should make the initial decision to convert to a stand-alone ED easier.

To be willing to shift to a stand-alone ED model, small communities' hospital boards may need to better understand the limited economic effect of conversions of hospitals to outpatient-only facilities. While the two communities that grew after hospital closures are anecdotal observations, we are not aware of any research showing the conversion of a hospital to an outpatient-only facility had large economic effects on rural communities.

A converted outpatient facility would also have the option of aligning with its area's larger hospital system to support some functions at the outpatient-only facility. For

example, the larger hospital could help with peer review of physicians, purchasing supplies, and billing for services. Under this option, the new outpatient-only facility could work cooperatively with other health care providers to provide continuity of care across settings.

Who would receive the rural fixed payment to maintain a 24/7 ED?

A facility that eliminated inpatient services (acute and post-acute swing services), accepted outpatient PPS rates, and converted to an outpatient-only facility would receive the fixed payment. To ensure that the funds were used as intended, the facility could be required to use the fixed payment for emergency standby capacity, ambulance service losses, telehealth capacity, and uncompensated care in the ED. The 24/7 ED could be required to be periodically recertified to determine that the facility was still isolated from full-service hospitals and was appropriately spending the annual fixed payments to operate a 24/7 ED. We refer to the combination of the stand-alone ED and its affiliated services (e.g., telehealth, ambulance, clinic services, rehabilitation services) as an outpatient-only hospital.

It is not clear how many providers would choose to convert from a PPS hospital or CAH status to an outpatient 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. (See online Appendix 2-B, available at <http://www.medpac.gov>, showing a map of all isolated low-volume hospitals more than 35 miles from another hospital. We use the 35-mile criterion because EDs less than 35 miles from a traditional hospital have the option to become an outpatient department of a neighboring hospital. In addition, the 35-mile criterion is the limit currently used in the SCH and CAH programs.)

Shifting from CAH status to a stand-alone ED would reduce patient cost sharing

Another consideration with regard to CAHs shifting to stand-alone ED status is the degree to which beneficiaries' cost-sharing obligations would decline when hospitals shifted from CAH status to PPS rates. Past Commission work suggests that the Medicare program's share of cost-based payments to CAHs for outpatient services (net of patients' coinsurance liabilities) is roughly equal

to PPS rates (Medicare Payment Advisory Commission 2012). Although the Medicare program would not realize significant program savings from shifting from CAH cost-based rates for outpatient services to PPS rates, beneficiary cost would decline dramatically. The reason is that beneficiaries' coinsurance at CAHs is set at 20 percent of charges, which is roughly 50 percent of the cost-based payment and often close to the full PPS payment rate (Medicare Payment Advisory Commission 2016a, Medicare Payment Advisory Commission 2011). When facilities switch from CAH status to PPS rates under stand-alone ED status, Medicare beneficiaries could see their coinsurance fall by 70 percent or more. For example, if the CAH billed \$700 for a Level 3 ED visit that cost \$350, the beneficiary would owe the CAH 20 percent of \$700 (\$140) in cost sharing. If the facility converted to a stand-alone ED, the payment rate for the service would fall to \$200 and PPS ED coinsurance would be \$40 (71 percent less than CAH coinsurance). However, given the widespread use of Medicare supplemental insurance that shields many FFS Medicare beneficiaries from coinsurance, the benefit for some beneficiaries with medigap policies in rural states would be a small reduction in medigap premiums.

RECOMMENDATION 2 - 1

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.**

RATIONALE 2 - 1

Struggling hospitals within 35 miles of another hospital can eliminate inpatient services and reduce their costs by becoming an outpatient department of a neighboring hospital. However, isolated rural facilities more than 35 miles from another hospital do not have an option to convert to a stand-alone emergency department. Therefore, communities that most need an emergency room but cannot support inpatient services also have the fewest payment options. This situation results in stand-alone EDs being financially unviable in most isolated rural markets. Creating a way to pay stand-alone EDs in isolated rural communities will help these areas maintain emergency department capacity. The option would be available to communities more than 35 miles from another hospital

that (1) never had a hospital, (2) had a hospital that closed, or (3) have an open full-service hospital that they want to convert to an outpatient-only facility.

IMPLICATIONS 2 - 1

Spending

- Most rural stand-alone EDs would be former CAHs. Under this recommendation, Medicare would make annual lump sum payments to CAHs that convert to become a rural stand-alone ED and maintain only outpatient services. These payments, if in the range of \$500,000, would be offset by savings from reduced payments for post-acute care (PAC) services as beneficiaries who might have received PAC services at the CAH are shifted to other PAC providers at a lower cost to Medicare. However, a small share of the outpatient-only facilities would be either former PPS hospitals or hospitals that would have closed without the new program. Preserving these hospitals and access to emergency care in these communities will add to program spending. The Congressional Budget Office estimates that the policy would increase spending by less than \$50 million per year.

Beneficiaries and providers

- Rural communities would have a new option for preserving emergency department access without having to maintain expensive inpatient capacity. Medicare beneficiaries would benefit from preserved local access to emergency care and the reduced coinsurance.

Urban areas: Incentives have led to an abundance of urban stand-alone EDs

The number of stand-alone EDs and the share of patient visits taking place in EDs have increased rapidly in recent years. These facilities improve access to services not available at doctors' offices and urgent care centers, but their Medicare payment rates need to be better aligned with the cost of care they provide.

Some researchers believe the growth in ED use may be partially due to patients' lack of access to other providers, changing practice patterns, or patients' desire for more immediate access to care (Gindi et al. 2016, Morganti et al. 2013, Pines et al. 2013). However, the increase in the number of stand-alone EDs and the increase in the volume of ED visits may also partly reflect incentives in

**TABLE
2-4**

Seventy-five percent of urban stand-alone emergency departments are located within 6 miles and a 10-minute drive of the nearest on-campus hospital emergency department, 2018

	Distance to the nearest on-campus hospital ED (in miles)						
	0-2	2-4	4-6	6-8	8-10	10-12	12 or more
Number of stand-alone EDs	23	35	26	13	5	5	5
Share of stand-alone EDs	21%	31%	23%	12%	4%	4%	4%
Cumulative share	21%	52%	75%	87%	91%	96%	100%
Average minutes from the nearest on-campus hospital ED	4.4	8.4	10.3	14.0	14.3	19.8	21.6

Note: ED (emergency department). The five market areas include Charlotte, NC; Cincinnati, OH; Dallas, TX; Denver, CO; and Jacksonville, FL. Components may not sum to totals due to rounding.

Source: MedPAC analysis of the location of hospitals and stand-alone EDs using ArcGIS data software and Google mapping.

both Medicare’s payment system and commercial insurer payment systems (Wilson and Cutler 2014). Recent analysis from three states suggests that stand-alone EDs treat patients who are more similar to patients treated at urgent care centers than patients treated at on-campus hospital EDs. Despite this analysis, under Medicare, OCEDs are paid the same as on-campus hospital EDs, making the OCED model of care financially attractive to hospitals in many markets.

Stand-alone EDs locate in certain markets and higher income zip codes rather than underserved areas

The stand-alone EDs identified in our June 2017 report were concentrated in 20 large metropolitan statistical areas (MSAs) in 2016 and accounted for over 60 percent of all stand-alone EDs.¹¹ These facilities tend to locate in zip codes with higher than average incomes and higher shares of patients with private insurance coverage (Medicare Payment Advisory Commission 2017, Schuur et al. 2016). We found that, in Houston and Denver, about 65 percent of stand-alone EDs were located in zip codes that represented only 35 percent of the city’s population but had an average household income above \$90,000. We found similar patterns in Charlotte, NC; Jacksonville, FL; Oklahoma City, OK; and Seattle, WA (markets without IFECs). Recent research has found that IFECs may be even more likely to locate in high-income areas (Dark et al. 2017). In interviews, stand-alone ED representatives stated that hospitals use stand-alone EDs to capture patient market

share and control patient service use. They also stated that a real estate analysis method—using variables such as the location of other EDs, population growth, household income, and insurance coverage—is used to identify areas with unmet demand for convenient ED services (Adeptus Health Inc. 2016).

Urban stand-alone EDs are in close proximity to on-campus hospital EDs

Our analysis of stand-alone EDs sought to distinguish between urban stand-alone EDs that provide access to urban areas that are relatively isolated from ED services and stand-alone EDs that create redundancies in access because they are in close proximity to existing on-campus hospital EDs. We examined five markets with urban stand-alone EDs (Charlotte, NC; Cincinnati, OH; Dallas, TX; Denver, CO; and Jacksonville, FL) and considered the distance of stand-alone EDs from the nearest on-campus hospital ED, both in driving distance (in miles) and driving time (in minutes). While we measured proximity as the distance to an on-campus hospital ED, policymakers could also opt to measure proximity from the stand-alone EDs to any other ED (on-campus ED or other stand-alone ED).

Overall, our analysis found that stand-alone EDs tend to be located in close proximity to on-campus hospital EDs. In 2018, 75 percent of urban stand-alone EDs in the five markets studied were within six miles of the nearest on-campus hospital ED, and 25 percent were more than six miles from the nearest on-campus hospital ED (Table 2-4).

In addition, using publicly available mapping software, we estimated that, on average, the EDs within 6 miles of the nearest on-campus hospital ED were roughly a 10-minute drive from the nearest on-campus hospital ED. Therefore, a beneficiary living exactly in between a stand-alone ED and an on-campus hospital ED six miles apart would need to travel three miles, or spend five minutes to drive, to the ED nearest their residence.

Patients served at stand-alone EDs in three states have lower acuity than patients at on-campus EDs

Three recent analyses of stand-alone EDs in Texas, Colorado, and Maryland demonstrate that patients served by stand-alone EDs tend to have less complex conditions than patients served by on-campus ED patients, but the prices paid to the stand-alone EDs are typically the same as on-campus EDs. Moreover, the analyses highlight that stand-alone EDs generally do not incur the same standby costs as on-campus EDs.

Texas

A study of commercial insurance claims for enrollees of Blue Cross and Blue Shield of Texas from 2012 to 2015 suggests that stand-alone EDs serve patients who are similar to those served by urgent care centers while being paid rates similar to hospital EDs (Ho et al. 2017). This study found substantial overlap in the type of cases seen at on-campus EDs, off-campus EDs, and urgent care centers, but it also found that on-campus EDs tend to receive the most difficult cases, such as open head or neck wounds. Among the top 20 most common diagnoses treated at each facility type, 12 diagnoses were common to all.¹² Three diagnoses at on-campus hospital EDs were not common to either stand-alone EDs or urgent care centers: kidney stones, nausea and vomiting, and complications of pregnancy. Five of the most common diagnoses at urgent care centers were not common to either stand-alone EDs or on-campus hospital EDs: eye inflammation, flu, other upper respiratory disease, pneumonia, and viral infections. All of the most common diagnoses at stand-alone EDs were also most common to on-campus EDs or urgent care centers. Despite the similarity in cases treated across the three facility types, stand-alone EDs appear to occupy a middle ground between urgent care centers and on-campus EDs with regard to the severity of patients they serve. For example, more acute medical diagnoses such as pregnancy complications and kidney stones and less complicated medical diagnoses such as eye inflammation and viral infections are not common to stand-alone EDs.

This study found that the standby costs of stand-alone EDs fall between the costs of on-campus hospital EDs and urgent care centers (Ho et al. 2017). Stand-alone EDs and on-campus hospital EDs must provide continuous access to emergency clinicians, laboratory services, and imaging services. The cost of meeting these requirements is higher than the costs at urgent care centers, which typically are not open 24/7 and are generally not staffed with physicians specializing in emergency medicine. While the costs of stand-alone EDs are higher than urgent care centers, the authors also contend that their costs are lower than on-campus hospital EDs, in part because stand-alone EDs largely do not maintain the on-call physician capacity for specialists necessary to serve patients with major trauma injuries (e.g., head and neck wounds or gunshot wounds), stroke, and ST-elevation myocardial infarctions. The authors suggest this difference in patient severity is linked to the fact that ambulances preferentially route higher acuity patients to on-campus hospital EDs that maintain operating rooms and overnight inpatient bed capacity. In our interviews with ambulance industry representatives, they confirmed this view, stating that ambulance drivers are instructed to take any potential inpatient admission to an on-campus hospital ED because stand-alone EDs do not have operating rooms or overnight beds. Another study found that ambulance drivers transporting trauma cases typically bypassed an isolated rural stand-alone ED because on-campus hospital EDs were more likely to have trauma care capacity (Lawner et al. 2016).

Colorado

Claims data for privately insured patients in Colorado in 2014 show that most patients served by stand-alone EDs were treated for non-life-threatening conditions, similar to conditions treated at urgent care centers. These data also show that the patients served by stand-alone EDs are somewhat different from those served at on-campus hospital EDs. In July 2016, Colorado's Center for Improving Value in Health Care (CIVHC) compared claims data from nine stand-alone EDs with claims from urgent care centers and on-campus hospital EDs. CIVHC concluded that, among the top 10 conditions for which privately insured patients sought care at stand-alone EDs, 7 were for non-life-threatening conditions. At urgent care centers, all 10 of the top 10 conditions were non-life threatening, whereas at on-campus hospital EDs, only 3 of the top 10 were for non-life-threatening conditions. Between stand-alone EDs and urgent care centers, six of the most common conditions overlapped, and none of them were life threatening. Between stand-alone EDs

and on-campus hospital EDs, four of the most common conditions overlapped, and three were non-life threatening.

Using the same data, CIVHC found that, in 2014, privately insured patients paid higher amounts—exceeding 10 times the amount—for treatment at stand-alone EDs compared with treatment at urgent care centers. For example, in 2014, the average payment amount for an upper respiratory infection (a non-life-threatening condition) at stand-alone EDs was \$1,114, compared with \$124 at urgent care centers. Similar differences existed for other conditions.¹³

Maryland

A 2015 report from the Maryland Health Care Commission (MHCC) concluded that the patients served by three stand-alone EDs generally had lower acuity conditions compared with on-campus EDs (Maryland Health Care Commission 2015). MHCC reported that, in 2014, between 3 percent and 6 percent of patients served by the three stand-alone EDs were later admitted as inpatients to a hospital compared with between 15 percent and 19 percent of patients served at the nearest competing hospital EDs. In addition, at the Maryland stand-alone EDs in two towns, 97 percent and 95 percent of patients, respectively, arrived as walk-ins rather than by ambulance. By contrast, the Emergency Department Benchmarking Alliance and the American College of Emergency Physicians reported that, in 2013, 17 percent of all ED patients nationally arrived at the ED by ambulance (Augustine 2014).

MHCC also concluded that patients served by the three Maryland stand-alone EDs in 2014 were younger, more likely to have private insurance coverage, and had treatment options other than the ED available to them. Compared with all EDs in Maryland, the stand-alone EDs tended to treat a larger share of children and a smaller share of patients older than 41, tended to serve a slightly larger share of privately insured patients, and tended to serve a lower share of Medicare and Medicaid patients.

Required standby capacity of urban stand-alone EDs is less than that of on-campus hospital EDs

Information gathered from site visits to stand-alone EDs and recent research supports ambulance suppliers' statements that stand-alone EDs generally do not maintain the capacity to treat major trauma cases such as major head injuries. Trauma, stroke, and heart attack patients are

more often transported to on-campus hospital EDs where there are backup surgical capabilities, operating rooms, cardiac reperfusion capabilities, and specialized stroke care. Other research has reported ambulances bypassing stand-alone EDs, specifically studies examining the stand-alone ED phenomenon in Maryland (Lawner et al. 2016, Maryland Health Care Commission 2015). Rural EDs that are especially far from other care are the exception; in these areas, ambulances might rely on rural EDs to stabilize trauma patients, and in some cases might use them as a location to begin clot-busting drugs on stroke patients. This exception suggests that isolated off-campus EDs that are a substantial distance from any hospital-based ED can be called on to have a wider range of standby capacity than OCEDs located 10 or 15 minutes from a hospital campus.

Aligning payments to urban stand-alone EDs with the acuity of their patients

The growth in stand-alone EDs in recent years suggests that existing Medicare and private-insurer payment policies encourage providers to treat patients in higher paying settings such as EDs rather than lower paying settings such as urgent care centers. The Commission's position on aligning payment rates across settings is that Medicare should ensure that patients have access to settings that provide the appropriate levels of care and that Medicare should base payment rates on the resources needed to treat patients in the most efficient setting. The concern in the case of stand-alone EDs is that providers seek to gain market share for low-severity conditions that could be treated more efficiently in other settings. For example, some hospitals are building ED facilities or partnering with IFECs to enable them to bill for the higher ED rates, when these conditions could be treated at urgent care centers.

Options for paying urban OCEDs less than full Type A ED rates

To account for the lower standby costs and the lower acuity of patients served at OCEDs, the Commission considered two alternatives to current Type A ED payment rates. The Commission's intent was to better align payment rates with the costs of OCEDs, thereby reducing the incentive to shift lower acuity cases to the ED setting. These two alternative payment rates were intended to lie between the rates of on-campus hospital EDs and urgent care centers.

In public discussion, the Commission initially considered paying OCEDs Type B ED rates because the acuity of

their patients is similar to the mix of patient conditions served at EDs receiving Medicare Type B ED payment rates. However, current Type B payment rates contain an anomalous characteristic that results in payments for Type B Level 1 cases (the lowest level) being higher than Type B Level 2 cases (\$102 for Level 1 cases versus \$91 for Level 2 cases) and higher than Type A Level 1 cases (\$102 for Type B Level 1 cases versus \$69 for Type A Level 1 cases) (Table 2-2, p. 41). This anomaly causes the difference between Type A and Type B payment rates to vary widely across each of the five ED levels.¹⁴ On average, across all five ED service levels, Type B rates are 30 percent lower than Type A rates.

To establish payment rates for OCEDs that lie between those for on-campus hospital EDs and urgent care centers, while reducing payments consistently across the five levels of ED services, Medicare should reduce Type A ED rates by a flat percentage. Reducing the Type A rates by 30 percent would be roughly equivalent to using Type B rates and would avoid the anomaly in the Type B rates. See online Appendix 2-A, available at <http://www.medpac.gov>, for a summary of the proposed urban policy.

Urban stand-alone ED recommendation

Urban OCEDs may provide the benefit of some services that are not available at urgent care centers and doctors' offices, but Medicare appears to be overpaying these facilities relative to what is paid to on-campus hospital EDs that receive more difficult cases. While most urban stand-alone EDs are in close proximity to on-campus hospital EDs, some are located far from on-campus hospital EDs and likely provide unique access to ED services for their local community. Paying these more isolated urban stand-alone EDs higher Type A rates, with no percentage reduction applied, may be justified.

RECOMMENDATION 2-2

The Congress should reduce Type A emergency department payment rates by 30 percent for off-campus stand-alone emergency departments that are within six miles of an on-campus hospital emergency department.

RATIONALE 2-2

The structure of the Medicare payment system for ED services creates incentives for providers to treat lower intensity patients in EDs rather than at urgent care centers, which are paid less than half the Type A payment rates for ED services. The Commission found that urban stand-

alone EDs tend to treat lower intensity patients and incur less standby capacity costs than on-campus hospital EDs because they generally do not maintain services such as trauma care or operating rooms. To better align their payments and costs, Medicare should pay OCEDs at lower rates than on-campus hospital EDs, but at higher rates than urgent care centers.

However, paying the current higher Type A ED payment rates to urban OCEDs that are not in close proximity to on-campus EDs may be justified.¹⁵ These more isolated OCEDs are more likely to be providing their local community with unique access to ED services. The Commission estimates that 25 percent of urban stand-alone EDs are located more than six miles from an on-campus hospital ED, and 75 percent are located within six miles. In response to industry concerns and for operational simplicity, the Commission used a threshold based on the measurement of distance in road miles rather than driving time, and the six-mile threshold appeared to be a natural breaking point in the proximity data. In addition, the Commission found that the 6-mile distance translated into roughly a 10-minute drive. Our six-mile proximity threshold could result in stand-alone EDs locating just beyond the six-mile threshold and in relatively close proximity to other stand-alone EDs. To avoid this dynamic, should the Commission's recommendation be implemented, policymakers might consider an alternative measure of proximity as the distance between the stand-alone ED and any other ED (on campus or stand alone).

The Commission's recommendation to reduce payment rates to OCEDs is intended to align payment rates with the relative costs of OCEDs. Timely congressional action in response to this recommendation would help ensure that hospital systems do not invest significant amounts of capital in OCEDs that are not necessary to ensure appropriate access to emergency care.¹⁶ Our recommendation to reduce payment rates to certain urban OCEDs by 30 percent, making those rates more comparable with Type B payment rates, may reduce the incentive to invest in such facilities.¹⁷ The 30 percent reduction reflects the current best information available, but we note that the Secretary of Health and Human Services could be given the authority to gather additional information on OCEDs' Medicare claims data and OCEDs' costs. This information will enable policymakers to adjust the 30 percent reduction in the future as new information becomes available and the marketplace shifts.

To gather the necessary claims and cost data on OCEDs, policymakers must make two specific administrative changes to hospital-related datasets. First, Medicare will need to identify OCEDs' Medicare claims. In 2016, the Commission recommended that "the Congress should require hospitals to add a modifier on claims for all services provided at off-campus stand-alone ED facilities" (Medicare Payment Advisory Commission 2016b). To date, this recommendation has not been enacted. Second, Medicare will need to require hospitals to report the costs of OCEDs separately on annual hospital cost reports made to CMS. Once OCED claims can be tracked and OCED cost and charge data gathered, CMS could estimate the relative costs of on-campus EDs and OCEDs. At that point, the Secretary could modify the magnitude of the recommended 30 percent reduction to Type A ED payment rates.

The Commission has made a judgment in determining that OCEDs located farther than six miles from an on-campus ED should be paid the full Type A rates. Other, more restrictive options could be considered. One option is to limit the full Type A rates to EDs more than six miles from any ED (including other OCEDs). This option would prevent a clustering of OCEDs. A second option is to impose a moratorium on new OCEDs. A third option is to reduce payment rates for non-ED services at OCEDs, such as paying office visits at affiliated clinics the rate paid to freestanding physician offices. This option would eliminate the exception written into Section 603 of the BBA of 2015, which requires that both ED and non-ED services (e.g., clinic visits and ancillary services) provided in off-campus EDs be paid the higher OPPS rates. The Commission also discussed a less restrictive option, in which OCEDs within six miles of an on-campus ED could continue to receive full Type A ED payment rates if they operated in a location where a hospital closed.

Spending

- Medicare payment rates for the five levels of ED services would each decline by 30 percent for urban off-campus EDs located within six miles of an on-campus hospital ED. Urban off-campus EDs located more than six miles from an on-campus ED would see no change in payment for ED services. The Congressional Budget Office estimates that this policy would result in an overall reduction in Medicare outpatient hospital spending of between \$50 million and \$250 million annually. Over five years, this policy could result in a reduction to Medicare outpatient hospital spending of less than \$1 billion. This reduction represents less than 1 percent of total Medicare outpatient hospital spending.

Beneficiaries and providers

- Medicare beneficiaries served at urban OCEDs located within six miles of an on-campus hospital ED would have lower cost sharing. In addition, this policy would reduce the incentive to develop new OCEDs in close proximity to on-campus hospital EDs. By leaving Medicare payment rates unchanged at urban OCEDs located more than six miles from an on-campus ED, Medicare would continue to ensure access to ED services in areas where they are needed most.
- The implications of this policy for hospitals and hospital systems is that 75 percent of existing urban OCEDs will see a 30 percent decline in payments for ED services. The remaining 25 percent of OCEDs, those located more than six miles from an on-campus ED, will not see a change in payment for ED services.

Future analyses

The Commission has expressed interest in future research concerning the standby costs of different types of EDs and Medicare payment rates for urgent care centers and micro-hospitals. That research could lead to better alignment of payment rates for on-campus hospital EDs, OCEDs, urgent care centers, and micro-hospitals. The objective would be to create incentives for providers to use the appropriate setting to treat patients' needs. ■

Endnotes

- 1 Data separating Medicare and non-Medicare ED use for 2015 and 2016 were not available at the time of publication. Therefore, all-payer data were used to demonstrate the trend in outpatient ED use from 2010 to 2016.
- 2 Hospitals' ED claims that result in a hospital admission are bundled into a diagnosis related group and paid through the inpatient prospective payment system.
- 3 The relative weights placed on Type A payment rates are based on the geometric mean cost of services in Type A EDs relative to the average cost of a clinic visit. The relative weights placed on Type B payment rates are based on the geometric mean cost of services in Type B EDs, which tend to be lower on average.
- 4 The anomaly in which Type B Level 1 ED visits are paid more than Type A Level 1 ED visits is due to the idiosyncratic cost and charge structure of the few hospitals billing Type B rates.
- 5 Older urgent care centers affiliated with a hospital are still permitted to bill hospital OPSS rates, which are on par with what the Type B facilities receive for an ED visit. They were grandfathered under a new site-neutral policy that eliminated facility fees for new hospital-affiliated urgent care centers and physician practices (Medicare Payment Advisory Commission 2016b).
- 6 The number of urgent care centers was obtained from the Urgent Care Association of America's website at <http://www.ucaoa.org/?page=IndustryFAQs#Size%20of%20Industry>.
- 7 Provider-based ED facilities are eligible for Medicare payment if they are in compliance with Medicare's provider-based department regulations, Medicare's conditions of participation, and the requirements of the Emergency Medical Treatment and Active Labor Act.
- 8 Section 603 defines *dedicated EDs* as facilities at which at least one-third of a facility's outpatient visits for the treatment of emergency medical conditions are on an urgent basis without requiring a previously scheduled appointment.
- 9 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. For example, others may categorize towns as rural if they are outside the commuting zone of larger cities, even if the county they are located in is considered part of an MSA. Given these different definitions of rural, we present information on hospital closures using both our definition (non-MSA) and the broader definition used by the Federal Office of Rural Health Policy, which incorporate non-MSAs and rural portions of counties within MSAs.
- 10 A few rural facilities currently operate stand-alone EDs with an attached outpatient clinic. A study by the University of North Carolina estimates that the cost of operating a low-volume 24/7 ED facility with an attached outpatient clinic is about \$5 million per year (Williams et al. 2015). Our discussions with rural hospital accountants and administrators of small rural stand-alone EDs support estimates in this range.
- 11 We defined large MSAs as those with 500,000 or more residents in 2015. In 2017, stand-alone EDs were located in 95 MSAs and 35 states.
- 12 The 12 diagnoses common to stand-alone EDs, on-campus hospital EDs, and urgent care centers were abdominal pain, allergic reactions, bronchitis, wounds, connective tissue disease, lower respiratory disease, upper respiratory infections, skin infections, back problems, sprains, superficial injuries, and urinary tract infections.
- 13 Private insurers in Colorado pay stand-alone EDs more for other services associated with non-life-threatening conditions compared with the same services at urgent care centers, including abdominal pain—other specified site (\$5,635 vs. \$151, respectively), bronchitis (\$1,139 vs. \$123, respectively), sinus infection (\$786 vs. \$125, respectively), and open finger wounds (\$1,035 vs. \$134, respectively). These high private-payer payments to stand-alone EDs in Colorado are consistent with data from Blue Cross Blue Shield of Texas (Ho et al. 2017) and with anecdotal reports in the popular press in other states (Kliff 2018).
- 14 The difference between Type A ED payment rates and Type B ED payment rates varies by level of ED service. Type B Level 1 payment rates are 49 percent higher than Type A Level 1 rates. Type B Level 2 payment rates are 27 percent lower than Type A Level 2 rates. Type B Level 3 payment rates are 28 percent lower than Type A Level 3 rates. Type B Level 4 rates are 41 percent lower than Type A Level 4 rates. Type B Level 5 payment rates are 45 percent lower than Type A Level 5 rates.
- 15 Policymakers may identify other situations where higher payments to urban OCEDs are warranted—for example, when an urban OCED is the result of the closure of its parent hospital.
- 16 The Commission's goal of adjusting payment rates to prevent the misallocation of capital based on mispriced services is not new. In earlier years, the Commission recommended

changing the inpatient prospective payment system to prevent overpayment to specialty hospitals treating relatively easier cases (Medicare Payment Advisory Commission 2006, Medicare Payment Advisory Commission 2005).

17 The extent to which the incentive to invest in OCEDs is reduced by a Medicare payment policy change would depend on the share of a given OCED's revenues that are tied to Medicare patient visits.

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