



Advising the Congress on Medicare issues

Stand-alone emergency departments

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Context

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

Hospital-based off-campus emergency departments (OCED)

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

Independent freestanding emergency centers (IFEC)

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

Regulation of Stand-alone EDs

State law

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

Medicare statute and regulation

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

Growth in stand-alone EDs and the relevance to Medicare

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

More facilities to bill Medicare

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

Four reasons for the growth of stand-alone EDs

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

Location of stand-alone EDs

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

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

Colorado

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

Maryland

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

Direction and policy discussion

The Commission may wish to consider:

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