Emergency department services provided at stand-alone facilities

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Overview

- Context of this research
- Trends in emergency visit use
- Hospital-based off-campus emergency departments (OCED)
- Independent freestanding emergency centers (IFEC)
- ED facilities and their competitors
- Policy questions

Context

- Commissioners expressed interest in trends of emergency visit use and growth of stand-alone emergency departments.
- Site-neutral concern that payment systems encourage providers to serve patients in the ED setting rather than the urgent care setting
- Stand-alone EDs may materially improve access in some cases communities but not others

Moderate growth in Medicare ED visits and rapid growth in spending

- 21 million Medicare ED visits (2013)
- ED visits grew moderately from 2008 to 2013
  - 1.6 percent per capita per year on average
  - Average age of Medicare beneficiaries remained stable
- ED visit growth from 2008 to 2013 varied by metro area
  - Higher in Dallas, Houston, and Atlanta
- Spending for ED visits grew rapidly from 2008 to 2013
  - $4.4 billion for outpatient and physician ED visits (2008)
  - $6.1 billion for outpatient and physician ED visits (2013)
  - 7.0 percent per capita growth per year on average
  - Additional spending for ancillary services such as imaging

High-severity ED visits grew rapidly

	Physician ED visits			Hospital outpatient ED visits		
ED level	Share (2008)	Share (2013)	Percent change in volume (2008 to 2013)	Share (2008)	Share (2013)	Percent change in volume (2008 to 2013)
Level 1	1%	0%	-15%	5%	2%	-43%
Level 2	4	2	-31	17	8	-36
Level 3	23	18	-13	34	31	11
Level 4	29	28	8	29	35	39
Level 5	44	52	30	14	24	82
Total	100	100	11	100	100	20

Source: Medicare hospital outpatient and physician claims

Note: Columns have been rounded and may not sum to 100 percent. Hospital outpatient claims include ED visits at hospital EDs and OCEDs.

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Hospital-based off-campus emergency departments (OCED)

- OCEDs increased 76 percent between 2008 and 2015
- 387 OCEDs in 2015
  - Operated by 323 hospitals (6 percent of hospitals)
  - 30 hospitals have more than one (ranging from 2 to 7 OCEDs each)
- Tend to be urban or suburban, affiliated with larger-than-average hospitals that are part of a system
- Geographic distribution:
  - Present in numerous metropolitan areas
  - Dallas, Houston, and Seattle have more than most other metro areas.
- Industry representatives and media reports suggest there is interest in developing more OCEDs in 2015 and 2016, particularly by large hospital systems.

OCED characteristics

Location and development

- Located less than 35 miles from hospitals, but often much less
- Range in size (20 to 100 patients per day)
- Developed in urban/suburban areas

Services and patients

- Offer limited set of services: 24/7 ED, imaging (x-ray, CT scan, ultrasound), on-site lab, on-site physician. No trauma or cardiac services requiring catheterization
- Common conditions: respiratory distress, head injury, infections, dehydration, sprains and fractures, and abdominal pain
- Compared to hospital EDs, more patients arrive as walk-ins and fewer by ambulance, especially for smaller facilities.

OCEDs: Medicare payment and data

- May bill Medicare if deemed provider-based by CMS
  - Must be licensed by state and adhere to Medicare Conditions of Participation
  - Must be financially and clinically integrated with the affiliated hospital
  - Must be located within a 35-mile radius of the affiliated hospital
- Bill Medicare under the outpatient PPS and Part B fee schedule for ED services
- OCED visits not separately identifiable in claims data
- Private insurers usually pay OCEDs as in-network providers under the affiliated hospital's contract

OCEDs: Growth raises questions

Do payment systems encourage providers to expand ED capacity?

- Interviewees stated ED visits are profitable, particularly the privately insured
- Interviewees stated OCEDs can be profitable with as few as 20 ED visits per day

Do beneficiaries know when ED visits are appropriate?

- 2010 RAND study found 13-27 percent of hospital ED visits could have been served at an urgent care center or retail clinic

Do OCEDs materially improve access to ED services?

- Interviewees stated development is focused on population growth and payer mix
- Some OCEDs may improve access, but others may be duplicative to existing capacity

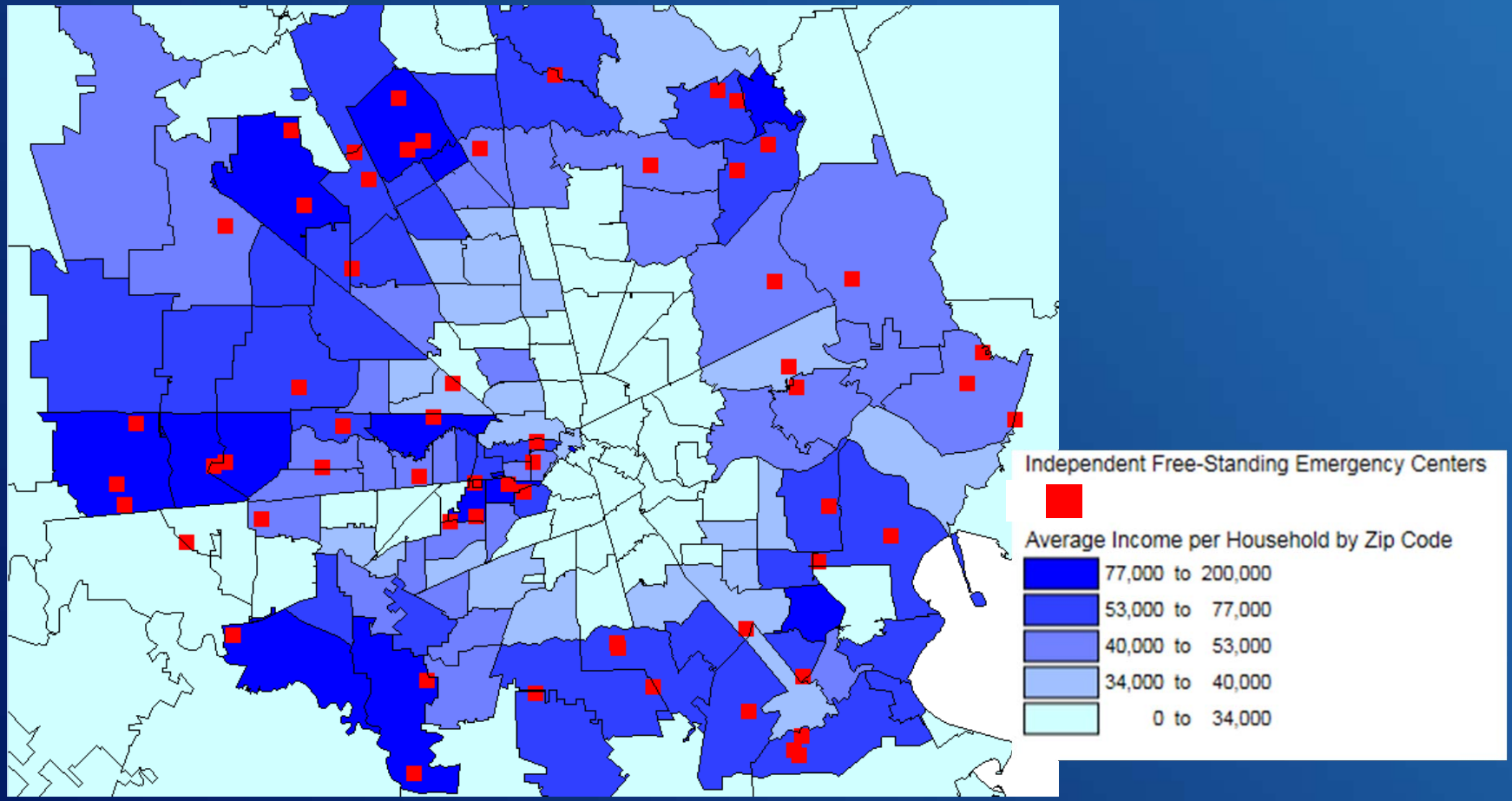
Independent freestanding emergency centers (IFEC)

- 172 IFECs, owned by 17 different for-profit entities in 2015
- 90 percent located in Texas, but also Colorado and Arizona
- Rapid growth in Texas (0 in 2010 and 156 in 2015)

- Similar to OCEDs in terms of the services they offer and that walk-ins make up most of their business
- Different from OCEDs is several ways
  - Concentrated in certain states due to state and municipal law
  - Cannot bill Medicare because they are not provider-based
  - Private insurers often pay them as out-of-network providers
  - Payer mix is more narrowly focused on privately insured patients

- In 2015 several started affiliating with or building hospitals in order to bill Medicare, Medicaid, and private insurers as provider-based EDs.

Relationship between IFEC location in Houston, Texas and ZIP code income



Source: Texas Department of Health Services and Census Bureau

Overlap in cases served at ED facilities and other competing facilities

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

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

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Policy discussion

The Commission could:

1. Consider ways CMS can begin tracking OCEDs in claims data,
2. Explore incentives inherent in Medicare payment systems that may influence the growth in stand-alone ED facilities,
3. Explore the ob**s**erved growth in the severity of ED visits and coding practices, under both the OPPS and PFS claims systems, or
4. Explore the effect that the growth of OCEDs has on beneficiaries, in terms of their understanding of when ED services are appropriate for use and out-of-pocket liability.