MedPAC Votes to Lower Urban Freestanding Emergency Department Payments

On April 5, 2018, at the public meeting for the Medicare Payment and Advisory Commission (MedPAC), the commissioners passed, via a unanimous vote, the following proposed recommendations related to reimbursement for freestanding emergency departments (FSEDs), a/k/a stand-alone emergency departments:

1. **“Congress should reduce Type A emergency department [ED] payment rates by 30 percent for off-campus stand-alone emergency departments that are within six miles of an on-campus hospital emergency department”**

   [emphasis added]; and,

2. **“Congress should allow isolated rural stand-alone emergency departments more than 35 miles from another ED to bill standard outpatient prospective payment system facility fees and provide such emergency departments with annual payments to assist with fixed cost.”**

   [emphasis added]

Currently, Medicare reimburses FSEDs under the outpatient prospective provider system (OPPS) by two different methods:

1. **Type A ED rates** reimburse hospital EDs open 24 hours per day; and,

2. **Type B ED rates** reimburse hospitals with EDs open fewer than 24 hours per day (note that these payments are approximately 30% lower than Type A rates).  

These recommendations should come as no surprise, given that MedPAC has published findings regarding trends and utilization of stand-alone EDs in both its June 2016 and June 2017 Reports to the Congress.  

In its most recent research, MedPAC found that, of the almost 6,000 FSEDs currently operating in the U.S., most have been open since 2010, and approximately two-thirds of these can currently bill Medicare for services.  

Additionally, FSEDs were found to be disproportionately located in areas with higher than average incomes and better (i.e., privately insured) consumers.  

This is thought to be, in part, due to varying state regulations with regard to FSED required services; ownership structure; and, operational requirements.  

Thus, in more lenient jurisdictions, FSEDs represent an opportunity for affiliated hospitals to expand their geographic footprint and reduce hospital-based ED overcrowding by increasing access in a nearby FSED.  

Additionally, FSEDs may allow a hospital system to cut into a competitor’s market service area to increase revenue by spending less money, as FSEDs do not maintain operating rooms or trauma teams and do not require on-call specialists, as a hospital-based ED would.

Hospital-affiliated off-campus emergency departments (OCEDs) – which comprised 64% of all FSEDs in 2016 – that are located within 35 miles of their affiliated hospital campus are paid the higher Type A rate for Medicare services (to compensate for the higher acuity patients treated), despite serving patients with acuity levels similar to those paid Type B rates.  

Should the first of MedPAC’s recommendations be passed, approximately 75% of OCEDs will face the recommended 30% payment reduction, saving Medicare anywhere from an estimated $50 to $250 million annually.

This MedPAC recommendation is not the first action focused on reducing outpatient site payments. In the Bipartisan Budget Act of 2015, Congress mandated that any medical services provided in an “off-campus provider-based department” no longer be reimbursed under the OPPS; the only service exempted from this new rule was ED services.  

The Centers for Medicare & Medicaid Services (CMS) consequently reduced payment for these entities to the applicable (and much lower) non-facility rate under the Medicare Physician Fee Schedule (MPFS).  

These, and subsequent changes by CMS, effectively reduced reimbursement to 25% of the original OPPS reimbursement fee for these outpatient entities, as of 2018.  

These changes have been met with criticism by the American Hospital Association (AHA), which called the previous payment reductions “arbitrary and capricious.”  

Similarly, in reaction to the first of MedPAC’s most recent recommendations regarding adding FSED reimbursement reductions to the growing list, the AHA called the move “unfounded and arbitrary,” citing a lack of appropriate analytical data to support the recommendation.

Additionally, in 2016, MedPAC conducted an investigation regarding improving access to emergency care in rural areas, which included reviewing potential scenarios by which financially struggling, isolated hospitals, e.g., critical access hospitals (CAH), would be given the option to convert to outpatient-only facilities, e.g., an ED or a clinic with ambulance service, to preserve access and promote efficiency.  

As noted in this 2016 investigation, should MedPAC’s 2018

(Continued on next page)
recommendation be passed by Congress, it would result in a modest increase in spending, but with the benefit of potentially preserving access to emergency care in rural settings.\textsuperscript{15}

Many of the MedPAC commissioners commented that these recommendations should be considered just the beginning of a much broader avenue of inquiry regarding the appropriateness of emergency care utilization.\textsuperscript{18} The number of ED visits have grown 20% from 2000 to 2010; while more than three quarters of privately insured patients seen in the ED could be more appropriately cared for in a primary care setting, the average ED visit costs $580 more than an outpatient office visit, contributing to unnecessary healthcare spending.\textsuperscript{19} While hospital investment in FSEDs may have historically been a smart financial business move, MedPAC appears to be cognizant of the fact that it may not be fiscally advantageous for federal health insurance programs. As Congress has historically agreed with MedPAC’s recommendations regarding the reduction of payment for certain outpatient services,\textsuperscript{20} investors and health systems should be wary of another imminent reimbursement reduction.

\begin{itemize}
\item \textsuperscript{2} Ibid, p. 12.
\item \textsuperscript{4} MPAC, June 2016, p. 212-213; Ibid, p. 245-264.
\item \textsuperscript{5} Stensland, Gaumer, McClendon, April 5, 2018, p. 3.
\item \textsuperscript{6} MPAC, June 2017, p. 256-257.
\item \textsuperscript{9} MPAC, June 2017, p. 248; Stensland, Gaumer, McClendon, April 5, 2018, p. 5-6.
\item \textsuperscript{10} MPAC, April 5, 2018, p. 9.
\item \textsuperscript{12} “Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; Electronic Health Record (HER) Incentive Programs; Payment to Nonexcepted Off-Campus Provider-Based Department of a Hospital; Hospital Value-Based Purchasing (VBP) Program; Establishment of Payment Rates Under the Medicare Physician Fee Schedule for Nonexcepted Items and Services Furnished by an Off-Campus Provider-Based Department of a Hospital” Federal Register Vol. 81, No. 219, November 14, 2016, p. 79699-79719.
\item \textsuperscript{13} AHA, September 2017.
\item \textsuperscript{14} Ibid.
\item \textsuperscript{16} MPAC, June 2016, p. 204.
\item \textsuperscript{17} MPAC, April 5, 2018, p. 12.
\item \textsuperscript{18} Ibid, p. 44-45.
\item \textsuperscript{19} “Reducing Inappropriate Emergency Department Use Requires Coordination with Primary Care” Robert Wood Johnson Foundation, Quality Field Notes, No. 1, September 2013, https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf407773 (Accessed 4/24/18), p. 1.
\item \textsuperscript{20} Dickson, April 5, 2018.
\end{itemize}
Todd A. Zigrang, MBA, MHA, ASA, FACHE, is the President of **Health Capital Consultants (HCC)**, where he focuses on the areas of valuation and financial analysis for hospitals, physician practices, and other healthcare enterprises. Mr. Zigrang has over 20 years of experience providing valuation, financial, transaction and strategic advisory services nationwide in over 1,000 transactions and joint ventures. Mr. Zigrang is also considered an expert in the field of healthcare compensation for physicians, executives and other professionals.

Mr. Zigrang is the co-author of “[The Adviser’s Guide to Healthcare – 2nd Edition](https://www.aicpa.org) [2015 – AICPA], numerous chapters in legal treatises and anthologies, and peer-reviewed and industry articles such as: *The Accountant’s Business Manual* (AICPA); *Valuing Professional Practices and Licenses* (Aspen Publishers); *Valuation Strategies: Business Appraisal Practice*; and, *NACVA QuickRead*. In addition to his contributions as an author, Mr. Zigrang has served as faculty before professional and trade associations such as the American Society of Appraisers (ASA); American Health Lawyers Associate (AHLA); the American Bar Association (ABA); the National Association of Certified Valuators and Analysts (NACVA); Physician Hospitals of America (PHA); the Institute of Business Appraisers (IBA); the Healthcare Financial Management Association (HFMA); and, the CPA Leadership Institute.

Mr. Zigrang holds a Master of Science in Health Administration (MHA) and a Master of Business Administration (MBA) from the University of Missouri at Columbia. He is a Fellow of the American College of Healthcare Executives (FACHE) and holds the Accredited Senior Appraiser (ASA) designation from the American Society of Appraisers, where he has served as President of the St. Louis Chapter, and is current Chair of the ASA Healthcare Special Interest Group (HSIG).

John R. Chwarzinski, MSF, MAE, is Senior Vice President of **Health Capital Consultants (HCC)**. Mr. Chwarzinski’s areas of expertise include advanced statistical analysis, econometric modeling, as well as, economic and financial analysis. Mr. Chwarzinski is the co-author of peer-reviewed and industry articles published in *Business Valuation Review* and *NACVA QuickRead*, and he has spoken before the Virginia Medical Group Management Association (VMGMA) and the Midwest Accountable Care Organization Expo. Mr. Chwarzinski holds a Master’s Degree in Economics from the University of Missouri – St. Louis, as well as, a Master’s Degree in Finance from the John M. Olin School of Business at Washington University in St. Louis. He is a member of the St. Louis Chapter of the American Society of Appraisers, as well as a candidate for the Accredited Senior Appraiser designation from the American Society of Appraisers.

Jessica L. Bailey-Wheaton, Esq., is Vice President and General Counsel of **Health Capital Consultants (HCC)**, where she conducts project management and consulting services related to the impact of both federal and state regulations on healthcare exempt organization transactions and provides research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services. Ms. Bailey-Wheaton is a member of the Missouri and Illinois Bars and holds a J.D., with a concentration in Health Law, from Saint Louis University School of Law, where she served as Fall Managing Editor for the *Journal of Health Law & Policy*.

Daniel J. Chen, MSF, is a Senior Financial Analyst at **Health Capital Consultants (HCC)**, where he develops fair market value and commercial reasonableness opinions related to healthcare enterprises, assets, and services. In addition, Mr. Chen prepares, reviews and analyzes forecasted and pro forma financial statements to determine the most probable future net economic benefit related to healthcare enterprises, assets, and services, and applies utilization demand and reimbursement trends to project professional medical revenue streams, as well as ancillary services and technical component (ASTC) revenue streams. Mr. Chen has a Master of Science in Finance from Washington University St. Louis.