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Medicare Payment Advisory Commission (MedPAC) Meeting
April 7-8, 2016

Ronald Reagan Building, International Trade Center
1300 Pennsylvania Avenue, NW
Washington, DC 20004

Friday, April 8
8:30 am to 10:00 am

"Improving Efficiency and Preserving Access to Emergency Care in Rural Areas" (Staff Contact: Jeff Stensland and Zach Gaumer)

What You Need to Know

- The Commissioners took no action today on rural emergency care services. Rather they discussed a possible new payment methodology whereby CAHs shift to outpatient only with ER services under a grant-like program.
- Commissioner Herb Kuhn gave six reasons why he liked converting CAHs under either design given that the conversion is optional, not mandatory: telehealth; use of grants gives maximum flexibility; a reversing back option; partnering with a regional provider; regulatory reform; and quality measure development for low volume situations.

BACKGROUND

Medicare has a long-standing objective to preserve access to hospital services. The current strategy is to pay higher inpatient rates for rural PPS hospitals and to provide cost based payment for critical access hospitals (CAHs). There are four existing strategies to preserve emergency services access in rural areas: (1) sole-community hospitals receive an add-on payment; (2) Medicare dependent hospitals (MDH) receive an an-on payment to inpatient rates; (3) low-volume adjustment, at add-on to inpatient rates (can also be sole-community/MDH); and (4) CAH. Two problems have developed with these approaches: they are increasingly inefficient and they are becoming less successful in preserving access.

Most rural hospitals are CAHs with cost-based reimbursement. This favors higher-profit/high-cost hospitals and encourages non-emergency services like imaging and swing beds. It also can lead to excess cost growth.

MedPAC COMMISSION ACTION

The Commissioners took no action today on rural emergency care services. Rather they discussed a possible new payment methodology whereby CAHs shift to outpatient only with ER services under a grant-like program. A chapter on rural emergency care services will appear in the June 2016 Report to Congress.

SUMMARY

Staff said that in addition to declining admissions at CAHs, there have been 41 rural closures from 2013 to March 2016 (54 closures if rural parts of MSAs are included). The distance between the nearest hospitals varied widely among the closures, so it is difficult to say one trend is causing the closures. 14 of

the 41 closures were CAHs. High costs per inpatient day absorbed the additional payments. These facts raised the question of whether emergency services would be financially viable if we redirected the supplementary dollars from inpatient services to the ED services?

This question led staff to present the goals of an outpatient only option:

- Isolated hospitals (CAH or PPS) would have the option to convert (not mandatory)
- Would be required to maintain emergency access
- Improve efficient
- Assure community commitment by requiring matching grants from the county or local resources

Two designs could meet these goals. First is a 24/7 emergency department with primary care outpatient care services. The hospital would receive outpatient PPS rates per service through a fixed grant to help fund stand-by costs. The hospital would not provide inpatient care. Rather, patients would be stabilized and transferred to an inpatient hospital elsewhere. Post-acute SNF services would get PPS rates. Remaining issues with this design include what the product is Medicare is paying for, how to staff the ED, and whether to allow conversion back to a CAH or PPS hospital.

Option two would be a clinic plus ambulance service. The clinic would be open 12 hours per day and the ambulance available 24/7. This design would receive two types of payment – PPS rates per unit of service (like FQHC PPS) and a fixed grant to help pay for ambulance stand-by capacity and uncompensated care costs. The Kansas Hospital Association has experimented with this design. Remaining issues with this design are more difficult. Product definition is unclear as well as the minimum staffing levels and maximum ambulance response time. Also how to limit eligibility for the program is problematic as a woodwork effect might occur.

For both models, MedPAC has done work in its June 2012 Report to Congress on who low-volume isolated providers area. "Isolated" could be defined as being some minimum distance to the nearest competitor.

The effects of either option 1 or 2 are important, staff said. For rural beneficiaries, conversions mean maintained access to emergency services, but increased travel for inpatient care. However, outpatient rates will be paid at PPS rates and have lower co-insurance than at CAHs. For providers, the change is optional, not mandatory. Converting can create a pathway to financial viability, and the grant funds can be used to help recruit physicians. Cost structures will also be lower making the entity more compatible with ACOs and the movement toward value payment.

Commissioner Herb Kuhn gave six reasons why he liked converting CAHs under either design given that the conversion is optional, not mandatory:

- Telehealth can be used, especially under option 2, to help with the workforce issues. Kuhn would like to see further tie in with the MedPAC chapter on telemedicine and this rural emergency services issue
- The use of grants gives maximum flexibility to hospitals to meet the needs of their populations which is challenging at times particularly in the behavioral health arena
- It is essential that a reversing back option be allowed
- Partnering with a regional provider will allow for greater collaboration
- Regulatory reform is important like reforming the three day SNF rule
- Quality measures for low volume situations need to be created to better gauge quality in these situations

Commissioner Sue Thompson of UnityPoint in Iowa agreed with Kuhn's points, and she emphasized the partnership relationships between the hospital and larger networks as critical for moving toward ACOs. She also emphasized the need to workforce to staff these hospitals. Kathy Buto picked up on the workforce issues, and staff said that the need for primary care professionals actually goes down with a

24/7 emergency department. Staff also said they thought it would be easier to recruit physicians because burnout would be decreased. Commissioner Warner Thomas remarked that telehealth could be a solution to workforce problems. Thomas also said that the product definition of the hospital needs to be rethought to also include the entity as a diagnostic center as well.

Commissioners Jack Hoadley and Kathy Buto had specific questions about how the grants would work. Was it an application process, and were the grants from Medicare//CMS or from HRSA? Staff said that there was precedent from another program for the grant funds to come from Medicare, but later clarified in response to Kate Baicker that there was no other matching grant program in Medicare. Staff also said they did not envision an application process, but rather a set of criteria that would be used such that if the hospital met the criteria, it would receive grant funding.

Skin in the game by the local community was important to Vice Chair Jon Christianson. He said we need to be careful with the grant monies, and Medicare needs to think carefully about the grant match. Kate Baicker agreed no "entangled financing." The matching funds theme also morphed into a discussion about ongoing support v. start up design funding.

Commissioner Alice Coombs asked about EMTALA requirements, and staff said that EMTALA requirements would hold for these converted hospitals. State level rules govern what is required in an ED room, staff said.

Today's session ended with a discussion of "what [entities] exist in nature" for these designs. Kathy Buto and Jack Hoadley asked staff who said three or four states have tried design #2 including Wyoming, Tennessee and Arkansas.