SOUTH CAROLINA OFFICE OF
RURAL HEALTH

Investment. Opportunity. Health.

Free-Standing Emergency Departments and Alternatives for Rural Markets

South Carolina Office of Rural Health Conference

October 9, 2018

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ATLANTA | NASHVILLE | PORTLAND, ME
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Agenda

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- Current Landscape
- FSEDs and Other Potential Models
- Financial and Operational Considerations
- Market Considerations
- Conclusion

CURRENT LANDSCAPE

Current ED Climate

- Overall IP admissions have declined significantly
- Between 2010 and 2016, hospital outpatient ED visits increased by more than 7% per capita across all payers and 14.1% in Medicare
- In 2017, about 580 FSEDs were in operation, with 377 affiliated with a hospital
- Increased usage of urgent care centers and physician clinics with extended hours may be contributing to a decline in ED utilization for lower acuity
- Cases that previously resulted in hospital admission are now treated on an outpatient basis, leading to a greater proportion of higher acuity cases in the ED overall
- Access to ED coverage is critical nationwide, but is increasingly difficult in rural areas

Outpatient ED visits

ED payment level	2010 Number	2010 Share	2016 Number	2016 Share	Change in number of ED visits	Percentage point change in share of ED visits
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.

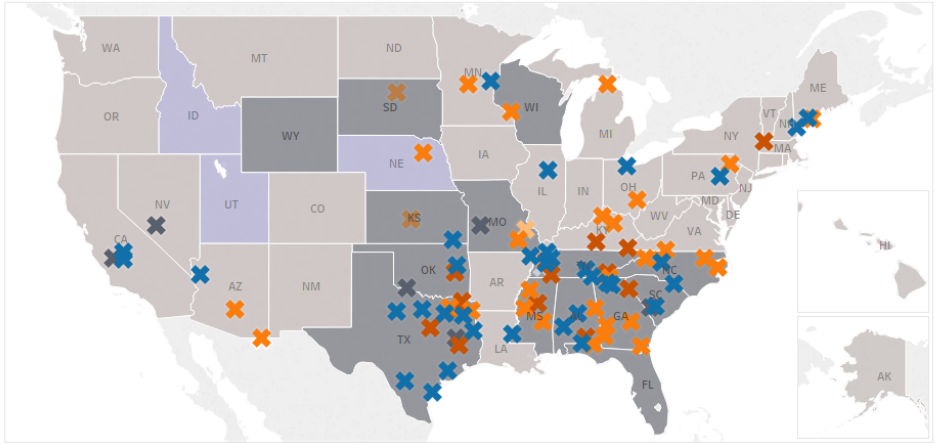
Source: MedPAC Report to the Congress June 2018

Rural Hospital Closures

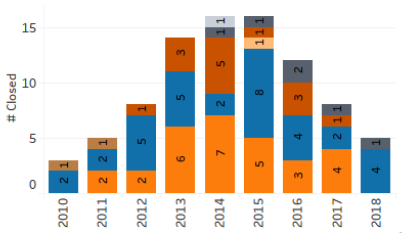
- 23 of the 51 rural hospitals that closed from 2013 through 2017 were over 20 miles from the nearest hospital
- Hospital closures in rural areas significantly reduce access to healthcare
- Median all-payer discharges in CAHs dropped from 600 to 335, increasing the cost of care for an inpatient-dependent payment model
- Median annual Medicare ED visits per CAH increased from 1,735 to 2,012 from 2010 to 2016

87 Closed Rural Hospitals

There have been 87 Rural Hospital closures since 2010 and 125 since 2005. These counts do not include those that have closed and re-open..



Closure Year	Hospital
2018	Chestatee Regional Hospital
	Coalinga Regional Medical Center
	McKenzie Regional Hospital
	Stamford Memorial Hospital
	Twin Rivers Regional Medical Center
2017	Campbellton-Graceville Hospital
	Care Regional Medical Center
	Copper Basin Medical Center
	Davie Medical Center-Mocksville



StateAbv	# Closed
TX	15
TN	9
GA	7
AL	5
MS	5
NC	5
KY	4
MO	4
AZ	3
CA	3
ME	3
OK	3
SC	3
KS	2
MN	2
OH	2
PA	2
VA	2
FL	1
IL	1
MA	1
MI	1
NE	1
NV	1
SD	1
WI	1

Closure Year	Prospective Payment System	Critical Access Hospital	Medicare Dependent Hospital	Sole Community Hospital	Re-based Sole Community Hospital	Disproportionate Share Hospital	Rural Referral Center	Total
2010	2				1			3
2011	2	2			1			5
2012	5	2	1					8
2013	5	6	3					14
2014	2	7	5	1		1		16
2015	8	5	1	1			1	16
2016	4	3	3	2				12
2017	2	4	1	1				8
2018	4			1				5
Total	34	29	14	6	2	1	1	87

Medicare Payment Type
- Prospective Payment System
- Critical Access Hospital
- Medicare Dependent Hospital
- Sole Community Hospital
- Re-based Sole Community Hospital
- Disproportionate Share Hospital
- Rural Referral Center

Current Status of Medicaid Expansion Decision
- Adopted the Medicaid Expansion
- Considering the Medicaid Expansion
- Not Adopting the Medicaid Expansion at this Time

Updated:9/21/2018

Source:The Cecil G. Sheps Center for Health Services Research & kff.org

Design:@GreggLathrop

Controversy in EDs

Off-campus emergency departments have caused controversy over increased utilization – "Build it, they will come"

- This appears to be primarily true in urban areas

Billing practices for off-campus EDs have led to some controversy

- Patients sometimes do not understand the difference between an FSED and an urgent care center, resulting in shocking bills for patients who receive care at an FSED
- FSEDs do not have the same fixed costs as hospital-attached Eds, raising the question of whether they should be reimbursed in the same way

For-profit FSEDs siphon off commercial patients needed by other hospitals to cover the charity and indigent care

- Private insurers' price paid per ED visit increased by 31% from 2012 to 2016
- However, more private insurers are denying payment for services not deemed emergent – most prevalent for lab and imaging services
- Burden is on the hospital to prove that the service was medically necessary to receive payment

Potential Payment Changes in EDs

- MedPAC proposed two major changes to payments for FSEDs to accomplish the following:
  - **Maintain access to ED services in rural areas**
  - Encourage efficient delivery of emergency services in urban areas
- Currently, Medicare only pays facility for emergency services if it maintains IP services, unless the ED is set up as a provider-based department of an affiliated hospital
  - Approximately 130 hospitals averaged less than 1 admission per day (all payers) and were more than 35 miles from other hospitals
  - These hospitals struggle with financial viability
    - While those that are cost-based may be margin neutral for IP services, overall investment of scarce resources may be misallocated to IP services
    - What happens if cost-based reimbursement goes away?

Why the Need for Payment Change?

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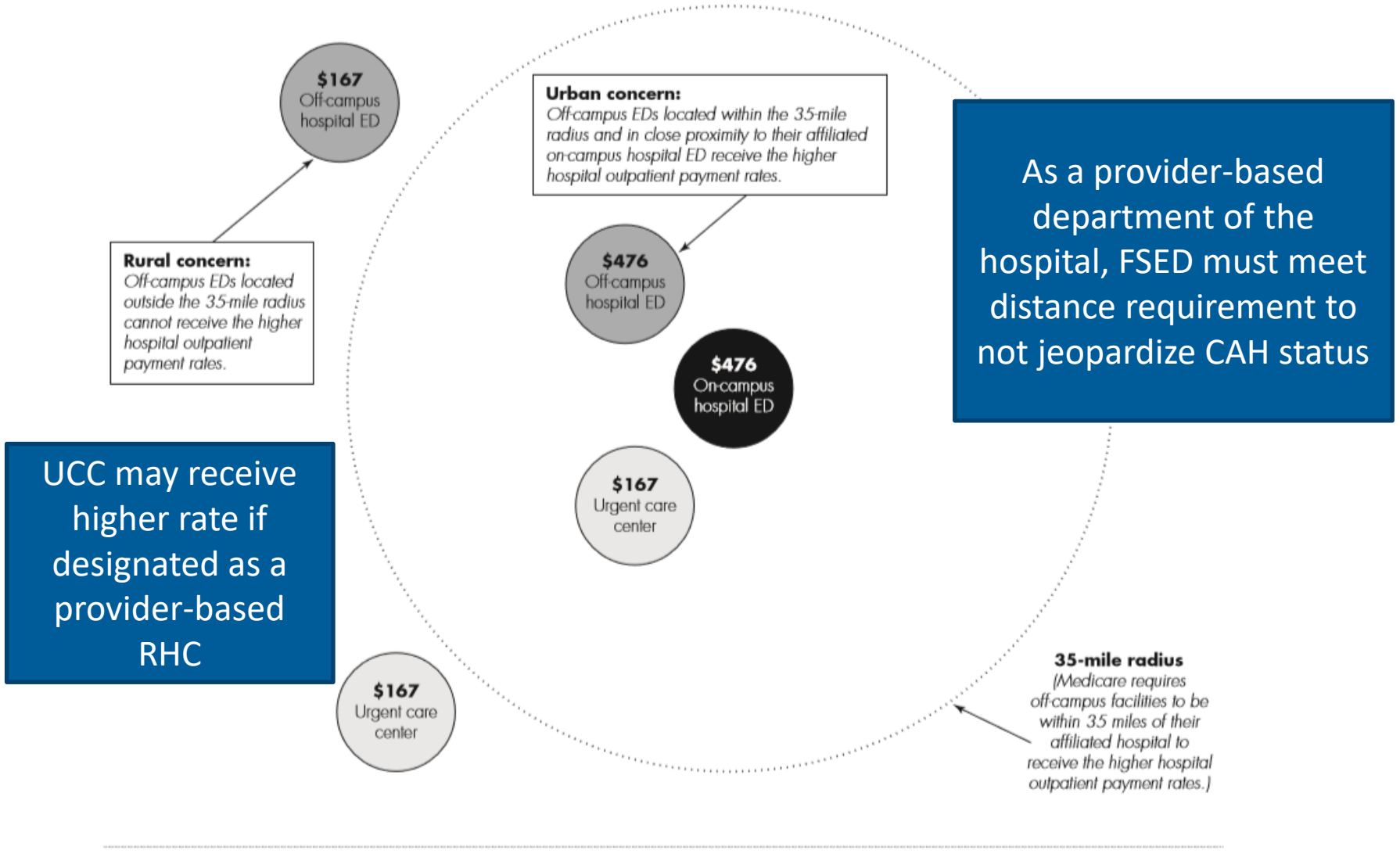

As a provider-based department of the hospital, FSED must meet distance requirement to not jeopardize CAH status

UCC may receive higher rate if designated as a provider-based RHC

Source: MedPAC Report to the Congress June 2018

FSEDS AND OTHER POTENTIAL MODELS

What Is an FSED?

"Freestanding emergency service" also referred to as an off-campus emergency service, means an extension of an existing hospital emergency department that is an off-campus emergency service and that is intended to provide comprehensive emergency service. The hospital shall have a valid license and be in operation to support the off-campus emergency service. A service that does not provide twenty-four hour, seven day per week operation or that is not capable of providing basic services as defined for hospital emergency departments must not be classified as a freestanding emergency service and must not advertise or display or exhibit any signs or symbols that would identify the service as a freestanding emergency service."

Source: South Carolina Code of Laws Section 44-7-130 (25)

Characteristics of an FSED

- Medicare recognizes 2 types of FSEDs:
  - Type A: Open 24/7
  - Type B: Open less than 24/7 (typically 12-16 hours per day)
- Required to have physicians on site at all times, though there are locations exploring APP models
- Lab and imaging must be operated 24/7
- Staff usually must be trained at a higher level than urgent care centers to accommodate higher-acuity patients
  - FSED staffing ratios for profitability take into account acuity mix and can be reduced by training nurses for high levels of acuity
- Ownership impacts reimbursement:
  - Hospital ownership: recognized by CMS and bills facility fees under the hospital's tax ID as a provider-based department
  - Independent ownership: not recognized as an ED and ineligible for facility fee for Medicare and Medicaid payments
    - Few states allow independent FSEDs – Texas, Rhode Island, and Delaware

FSED v Urgent Care Center

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- While UCCs may provide many of the same services as FSEDs, below are some of the required services differences

	Urgent Care/Emergency Care Clinic	Free-Standing ED
Open 24 hours a day, 365 days per year	X	✓
Trauma	X	X
IV fluids & medications	X	✓
Tele-stroke	X	X
On-site helicopter for transferring patients	X	X
Experienced ED trained doctors	X	✓
X-Rays	✓	✓
In-house lab tests	Some Tests	✓
Joint Commission Accredited	X	X
In-house specialty physicians	X	X
EMS transfer	X	✓
Average net patient revenue	$105 to $135	$350 to $500
Co-pay charged	$35 to $50	$75 to $100
Facility fee	One Invoice	Separate charges from facility and physician group

Microhospitals

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- 24/7 small scale inpatient facility
- No specific CMS designation – can be PPS or CAH depending on area
- Must be at least 50% inpatient beds to qualify as a hospital
- Usually 8 to 12 beds that are 15,000 to 50,000 square feet
- More frequent in urban areas
- Currently there are about 50 microhospitals open or under development
  - Located in only 8 states: Arizona, Colorado, Idaho, Missouri, Nevada, Pennsylvania, Oklahoma and Texas
  - Tenet Health and Dignity Health have been the leading large systems in utilizing this model of care

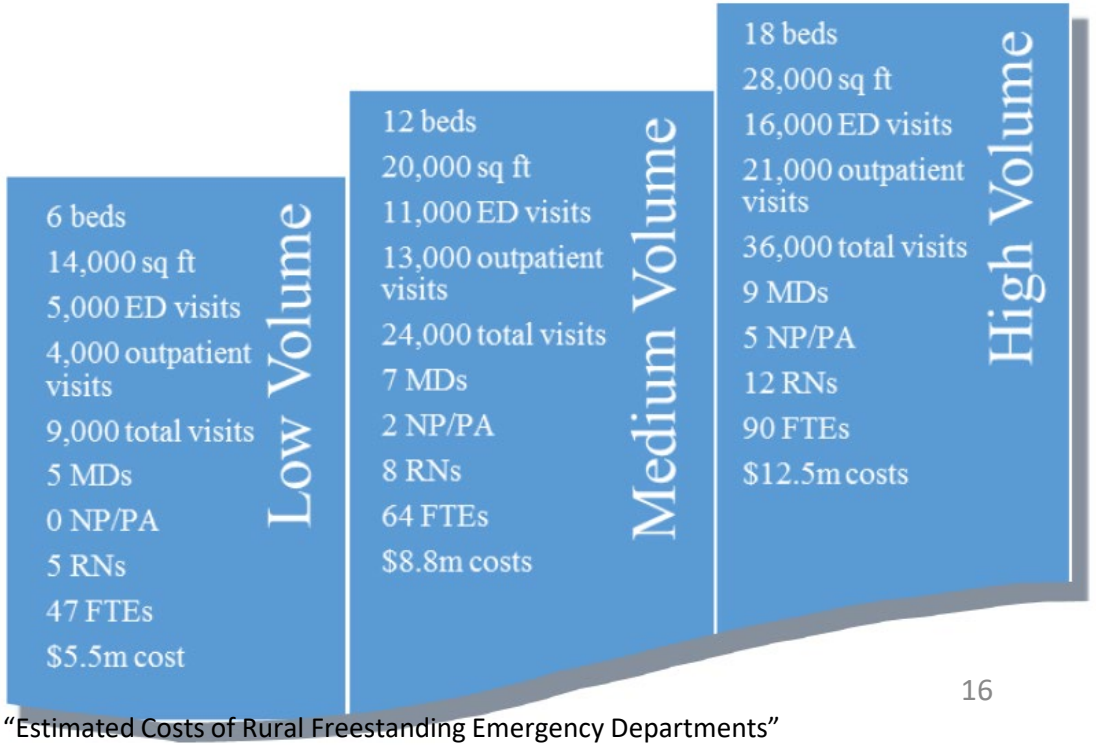
24-Hour Urgent Care/RHC

- 24-Hour Urgent Care designated as an RHC
  - If aligned and operated as a provider-based department of a hospital with less than 50 beds, Urgent Care center will receive un-capped cost-based reimbursement that could be higher than FSED rates received through OPPS
    - When the RHC is aligned under a CAH, the CAH may receive lower cost-based reimbursements due to the cost report step-down methodology applied to overhead cost
    - Cost-based reimbursement applies to both the technical and professional components
  - If aligned under a hospital with 50 beds or more, this alternative is not an appropriate financial alternative to an FSED due to the capped reimbursement rate
    - RHC capped rate of $82.30 per visit
    - FSED average rates $350 to $500
- Other considerations
  - Cannot receive EMS transport
  - Services may be different than an FSED depending on how it is set up (CT, X-ray, US availability)
  - Allows access to 340B reimbursement to parent, which can improve overall financial feasibility

FINANCIAL AND OPERATIONAL CONSIDERATIONS

Three Typical Sizes

- Volume will dictate appropriate size and fixed cost per patient
  - Operators indicate 20 ED visits per day can result in profitability without government support, but only with adequate levels of private insurance and a standard mix of acuity level
  - Necessary volume per provider if using a 24-hour UCC/RHC
- Example: Winnsboro, SC ED through Providence Health-Fairfield Memorial
  - 18,000 sq. ft.
  - 6 exam rooms, 2 trauma rooms
  - 21 miles from Midlands Health Center in Columbia (nearest hospital once Fairfield Memorial closes)



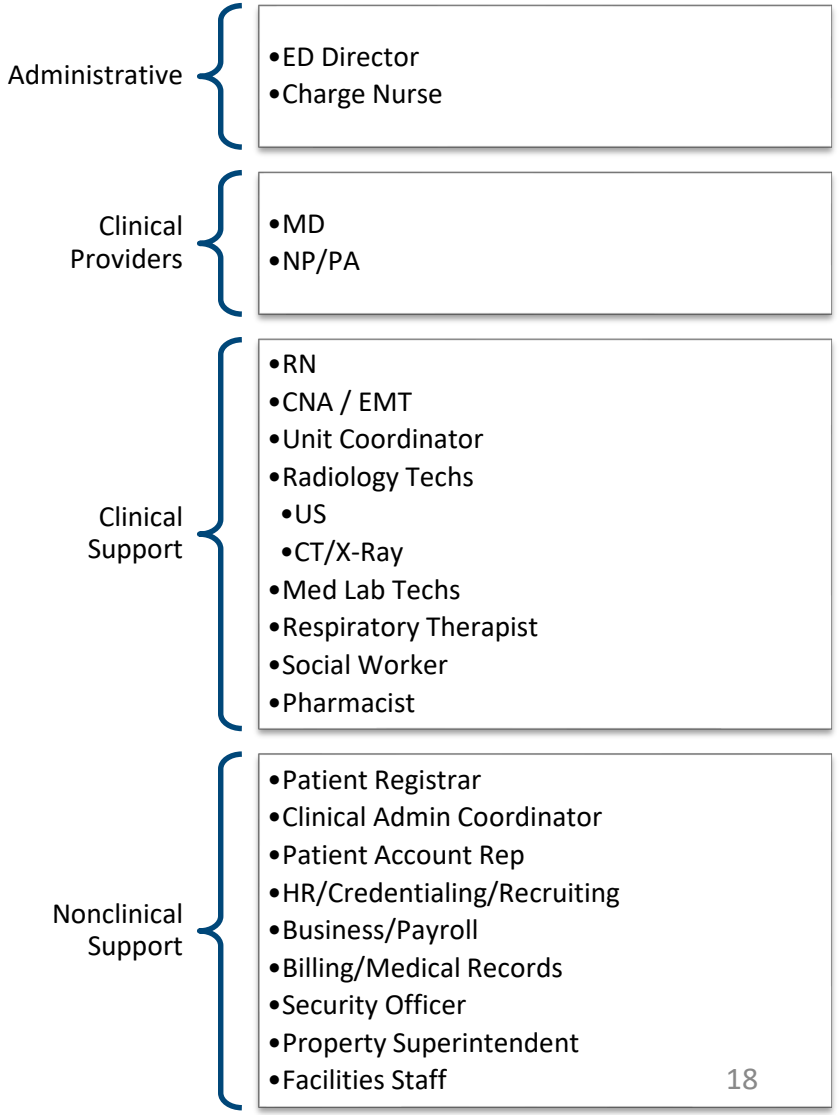
Source: Rural Health Research Gateway, "Estimated Costs of Rural Freestanding Emergency Departments"

Provider Relationships

- FSED must have a physician on site 24/7, meaning a minimum of 5.0 FTE physicians after accounting for vacation time
  - Approximately $1.3 - $1.6M in compensation and benefits expense
- May use APPs, but requires constant supervision that will be dictated by state
  - South Carolina is a restricted practice state
- Currently, many small towns lack the population to support efficient, high-quality acute care services
  - Employment of hospitalists has provided IP coverage for hospitals as the environment has shifted away from primary care physicians rounding on patients in the hospital

FSED Staffing

- Providers and clinical support will be based on potential volume
- Nonclinical support and some clinical support can be provided by a parent hospital to a certain level
- Some FSEDs outsource portions of nonclinical support
- Training adds a significant complication
  - Clinical providers and support have to be trained to a higher level than in EDs attached to a hospital
  - This can make these positions more costly
  - Expense trade-off may be increased number of RNs if appropriate level of training may not be found
- Billing/Coding, if centralized to a parent hospital, must understand the differences in the payments for an off-campus site compared to an attached ED



Additional Considerations

Payer Mix

- High Medicare, but still very high level on uninsured
  - In a cost-based reimbursement setting, uninsured patients are not included in the Medicare reimbursement
  - Putting patients in the lowest cost setting benefits communities with high uninsured patient rates
    - Preserving access to emergency services rather than to support IP services requires a shift in investment
    - MedPAC proposal and current proposed legislation support providing additional annual funding to cover fixed costs
- Commercial payers have penalized use of EDs unnecessarily
  - Anthem has co-pays of $150 to $300 for ER visits versus $10 to $75 for urgent care or physician office

Telehealth

- Mostly used for psychiatric care
- Cardiology and stroke and trauma can be used to determine need for transfers
  - Example: Copper Queen Community Hospital and its FSED in Douglas, AZ

EMS transport

- Distance to nearest trauma center
- Relationships – must have agreement in place with a hospital for transfers

MARKET CONSIDERATIONS

REACH Act

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- MedPAC has advocated for a shift in payment for rural hospitals to focus on maintaining access to needed services
- Report criticized cost-based reimbursement for being ineffective in maintaining access and incentivizing investments counter to preservation of care in isolated rural communities
- REACH Act / Rural Emergency Medical Center Act of 2018 introduced May 7, 2018 and creates a new designation
  - Focuses on CAHs and PPS hospitals with less than 50 beds willing to convert to a rural FSED
    - May provide observation care that does not exceed annual per patient overage of 24 hours or more than 1 midnight
    - Must have protocols in place for timely transfer of patients
  - Payments will include
    - Facility fee at the OPPS rate
    - Additional fee to account for fixed costs in furnishing rural ED services and the low volume of services – calculation of this amount is unclear, but currently estimated at $500,000 annually
    - Professional fee
    - Transportation services equal to 105% otherwise payable
    - Extended services equal to 110% of amount of payment that would otherwise be paid to a SNF
  - Allows redesignation as a CAH – though legislation is silent about redesignation for those grandfathered as a necessary provider

Community Support

- In rural communities, the low volumes and tendency to bypass for a larger hospital make the financial feasibility difficult
- Federal support can make these more financially stable, but some have relied on local governmental support
  - Land grants, tax breaks, etc.
- Example: County owned hospital in the Southeast
  - County hospital closed in 2014
  - County sought partners to potentially reopen as an FSED or a microhospital
  - Volumes supported an FSED, but local community pushed for access to additional services
    - Voters approved a 1-cent sales tax increase to provide the additional financial support necessary to go from an FSED to a microhospital
  - Microhospital is currently under construction that will include 10 patient rooms, 2 emergency ORs, endoscopy and cancer infusion (no OB)

Additional Considerations

Location	Space configuration	Areas that tend to provide challenges to the FSED
• High visibility and convenience will be critical for patients to choose an FSED rather than bypass to a larger hospital even if it is 20+ miles away	• Lower staffing requires that space be thoughtfully laid out for nurses to supervise several bays at once • Efficient layout will reduce or eliminate wait times for these low to moderate volume Eds, increasing the appeal to those that may drive farther to an attached ED	• Respiratory therapy • Radiology – a detailed utilization examination of the population is necessary to make sure the right investments are made in imaging • Lab – must be processed quickly to determine need for transport • Pharmacy

CONCLUSION

Final Thoughts

- FSED may be an appropriate mechanism to maintain care access in communities where a hospital has closed and no other ED is within 20 miles
- Staffing considerations will critically impact financial feasibility
- What is the strategy?
  - Hospitals currently struggling should at the very least be attuned to FSED and FSED-alternative options
- Be realistic about what the community can support – in terms of both volume and finance
- Payer mix – attention to both government payments and commercial trends will be critical components of decision making
  - Local government support may not be indefinite