effects of a flat facility fee for ED visits

HFMA'S RESPONSE TO THE CMS PROPOSAL

On Sept. 3, 2013, HFMA issued a letter to CMS advising against this change in payment policy due to the financial harm it could cause providers who serve the most complex cases while benefiting other providers without changing the health of populations served. The letter is available at hfma.org/FY14OPPSacutecare.

On July 19, 2013, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would impose a single payment rate for emergency department (ED) visits billed under the outpatient prospective payment system (OPPS), effective Jan. 1, 2014. This single rate would replace the five rates currently assigned to visits in 2013 based on intensity levels.

To assess the impact of this change on different types of hospitals, we looked at volumes of ED cases from the data used by CMS in promulgating the proposed rule. These data include national Medicare OPPS claims occurring during the 2012 calendar year. Volumes were paired with their current 2013 OPPS base payment rates for the five levels of intensity. The same claims were then used to project and compare total payment under the flat rate proposed for 2014. No adjustments were made for labor rates, outliers, or other factors. Hospitals were then compared based upon their location (urban versus rural), type of control, and bed size. Critical access hospitals were not included in the comparisons because they are not paid under the OPPS.

As one might expect from examining the proposed flat rate in comparison to the existing tiered rates, those facilities with a greater mix of lower-intensity ED cases are most likely to benefit from this flat rate system. For example, urban hospitals as a group are projected to experience a 0.28 percent reduction in total payment, with a fairly even distribution between hospitals that gain and those that lose, whereas rural hospitals overall are projected to experience a 3.3 percent increase in total payment, with a clear majority of rural hospitals enjoying increased payment.

PAYMENT RATES FOR ED CLAIMS UNDER THE MEDICARE OPPS: TIERED VERSUS PROPOSED FLAT-RATE PAYMENT

	Level of Intensity*				
	1	2	3	4	5
2013 rate	$51.82	$92.16	$143.36	$229.37	$344.71
Proposed 2014 Rate	$212.90				

* Range is from 1 to 5, with 1 being least intensive to 5 being most intensive.

IMPACT OF PROPOSED PAYMENT CHANGE: URBAN VERSUS RURAL

	Number of Hospitals		Percentage of Claims by ED Intensity Level					
Location	**Gain**	**Loss**	**1**	**2**	**3**	**4**	**5**	**% Payment Change**
Urban	1,173	1,112	2.30%	8.20%	30.90%	35.90%	22.60%	−0.28%
Rural	513	341	2.50%	10.70%	33.50%	32.20%	21.20%	3.30%
Total	1,686	1,453	2.36%	8.67%	31.43%	35.17%	22.40%	0.40%

A likely reason for this difference is that rural hospital EDs tend to have a less intensive mix of services than do their urban counterparts.

Also notable is the projected 0.4 percent greater overall cost under the flat-rate payment system as compared with the tiered-rate system. This difference probably reflects the intended annual update to payment rates issued each year. Note that the percentage change for urban and rural providers compared with the national total will not equate due to the greater number of urban providers in the total calculation.

When hospitals were grouped into staffed bed-size ranges, the data showed that the smallest facilities (i.e., those with fewer than 50 staffed beds) can expect to realize a 7.54 percent increase in total payment, whereas larger hospitals with more than 250 staffed beds can expect to see payment declines. Notably, the smallest bed-size group represents predominantly rural hospitals.

Analysis of the impact of the payment change on hospitals with different types of control disclosed the proposed model would be beneficial to majorities of proprietary and government hospitals.

This analysis can be easily replicated at the facility level using internal claims data applied to the payment rates shown in the top exhibit on page 146. Those facilities most likely to be affected (i.e., large urban providers treating proportionally more intensive cases) should play close attention the OPPS final rule and be prepared to adapt to lower payments should this provision of the rule be implemented. CMS is clearly making efforts to change the way ED claims are paid. If this proposal is not implemented for 2014, we are likely to see another strategy proposed for 2015. ●

This analysis was performed by American Hospital Directory, LLC, Louisville, Ky. For more information, contact William Shoemaker at wshoemaker@ahd.com.

IMPACT OF PROPOSED PAYMENT CHANGE: COMPARISON BY HOSPITAL STAFFED BED-SIZE

	Number of Hospitals		Percentage of Claims by ED Intensity Level					
Bed-Size Range	**Gain**	**Loss**	**1**	**2**	**3**	**4**	**5**	**% Payment Change**
<51	416	183	2.97%	13.62%	35.21%	28.42%	19.79%	7.54%
51-125	553	427	2.16%	8.03%	31.59%	36.04%	22.18%	2.91%
126-250	462	454	2.33%	7.73%	29.13%	36.97%	23.84%	−0.02%
251-500	210	323	2.28%	7.16%	28.85%	37.45%	24.27%	−1.92%
501+	45	66	2.51%	9.67%	33.71%	33.11%	21.00%	−2.64%
Total	1,686	1,453	2.36%	8.67%	31.43%	35.17%	22.37%	

IMPACT OF PROPOSED PAYMENT CHANGE: COMPARISON BY TYPE OF CONTROL

	Number of Hospitals		Percentage of Claims by ED Intensity Level					
Type of Control	**Gain**	**Loss**	1	**2**	**3**	**4**	**5**	**% Payment Change**
Not-for-Profit, Nongovernment	900	975	2.00%	8.80%	30.60%	35.50%	23.10%	−0.52%
Proprietary	470	293	3.10%	6.30%	34.90%	35.70%	20.10%	2.15%
Government	316	185	3.00%	11.10%	31.10%	33.10%	21.80%	0.67%
Total	1686	1453	2.40%	8.70%	31.40%	35.20%	22.40%	