Analysis of the Impact of Medicare's Recognition of Free-Standing Emergency Centers (FECs) on Federal Expenditures (2026 – 2035)

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Dobson | DaVanzo
HEALTH ECONOMICS CONSULTING

Submitted to:
National Association of Freestanding Emergency Centers (NAFEC)

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Introduction

Dobson DaVanzo & Associates, LLC (Dobson | DaVanzo) was commissioned by the National Association of Freestanding Emergency Centers (NAFEC) to conduct analyses that estimate the impact of Medicare's recognition of freestanding emergency centers (FECs) for payment purposes on Medicare expenditures between 2026 and 2035. This policy option was proposed in the *Emergency Care Improvement Act* (H.R. 3134). Additionally, in supplemental analyses, we explored the potential Medicare savings that might be associated with averted inpatient admissions from the use of Freestanding Emergency Centers (FECs) for three specific primary diagnoses, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF) and chest pain. We also analyzed the possible impact of expansion of Medicare coverage for FECs in rural areas.

Summary of Findings

Our analysis evaluated the ten-year budget impact of H.R. 3134 under two models: one without induced demand and one with modeled induced demand of 5.1%, based on a MedPAC 2017 analysis of hospital-owned off campus emergency departments (OCED), which are distinct from FECs. Each model included three scenarios for the expansion of FECs: static (100 FECs between 2026-2035), slow growth (FECs increase to 140 by 2035), and high growth (FECs increase to 185 by 2035). Key findings are described below.

Budget Impact of H.R. 3134

- Under the scenario with no induced demand, projected 10-year Medicare savings ranged from $83.3 million to $120.8 million depending on FEC growth. Savings attributable to lower Medicare expenditures in FECs ranged between $76.2 and $110.4 while savings attributable to non-coverage of Level 1 and 2 services ranged from $7.1 million to $10.3 million depending on FEC growth.
- Incorporating a 5.1% increase in emergency care utilization due to the new availability of FECs, dampened the net savings. Under this scenario with induced demand, 10-year Medicare savings ranged from $68.6 million to $99.5 million depending on FEC growth assumptions. Savings attributable to lower Medicare expenditures in FECs ranged between $61.5 and $89.2 while savings attributable to non-coverage of level 1 and 2 services remained consistent with the no-induced-demand model.
- Overall lower Medicare expenditures were driven by 1) a 25.5% lower cost per severity-adjusted patient in FECs compared to hospital-based EDs (HBEDs); and 2) the non-coverage of low-acuity (Level 1 and 2) services in FECs.

Supplemental Analyses

- In addition, we examined savings from inpatient hospital admissions potentially averted among beneficiaries using FECs for three conditions chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF) and chest pain.

- We estimate those savings at $229 million for those with COPD, $167 million for those with CHF and $46 million for those with chest pain over the 10-year period.
- Estimated savings for an alternative policy where Medicare coverage is only extended to FECs in rural areas that are 35 miles or a 15-minute drive from a hospital range from $6.2 to $9.4 million. Of those savings, between 5.5 million to $8.6 million are attributable to lower Medicare expenditures in FECs.

Background

Definition of Freestanding Emergency Centers (FECs)?

FECs are state-licensed providers of emergency care, delivering the same level of services a Medicare beneficiary would receive in a hospital-based emergency department (HBED). Legislation defines a FEC as a facility that:

- **Is staffed 24/7** with emergency room-certified physicians, emergency-trained nurses, as well as laboratory and radiology technicians available to provide emergency services;
- **Complies with federal Emergency Medical Treatment & Labor Act (EMTALA)** legislation and state freestanding emergency certification requirements;
- **Maintains referral arrangements with one or more hospitals** for patients requiring inpatient admission or specialized diagnostic and other services not available at the FEC;
- **Has an established a governing body** to determine, implement, and monitor policies governing the total operation of the facility; and
- **Meets all state requirements applicable to facilities** that furnish emergency medical services but do not accommodate stays exceeding 24 hours.

In summary, FECs adhere to the same standards and provide the same level of care as HBEDs, including stabilization of most emergent illnesses (e.g., heart attack, stroke, and trauma).

Pandemic-Related Regulatory Flexibility for Medicare Coverage of FECs

The COVID-19 public health emergency (PHE) raised concerns about the availability of hospital beds and emergency care. Additionally, many patients were hesitant to receive care in hospitals due to fears of exposure to the virus. To address both concerns, on April 21, 2020, CMS issued a policy waiver titled: *Guidance Allowing Independent Freestanding Emergency Departments to Provide Care to Medicare and Medicaid Beneficiaries during the COVID-19 Public Health Emergency.*

The guidance allowed licensed independent freestanding emergency departments (IFEDs) in Colorado, Delaware, Rhode Island, and Texas to be compensated at hospital Medicare

reimbursement rates for Medicare beneficiaries during the PHE period.[1] That is, FECs were allowed to operate and bill Medicare like hospital outpatient departments for the services they provided to Medicare beneficiaries.

This recognition provided CMS with a de facto Medicare demonstration project, primarily in Texas where the majority of FECs operate, in which to test the effect of Medicare program coverage of FECs on Medicare beneficiary patient care, expenditures and utilization.

Results from Prior Analysis Examining the Impact of Medicare Recognition of FECs During the Pandemic

In our October 2023 study, Dobson | DaVanzo conducted analyses of Medicare emergency department claims data during the PHE to examine differences in Medicare utilization and expenditures for HBEDs and FECs, under the Medicare waiver, in Texas as compared to other HBEDs in in other U.S. states. We analyzed 100% Medicare claims data for the 128 FECs who participated in the waiver between 2021 to 2022. All the FECs identified were in Texas. We observed the following from the study:

- There was no increase in ED utilization resulting from FEC participation in Medicare; that is, FEC utilization appeared to be a market share shift from hospital HEBDs.
- FECs delivered care at a 21.2 percent savings to Medicare on a severity level standardized basis as compared to HBED;[2] and
- FECs had substantially fewer inpatient admissions than HEBDs, on a risk adjusted basis.[3]

Objective of Current Analysis

H.R. 3134 would permanently reinstate Medicare coverage of FECs, with some modest changes in the payment methodology. This analysis is intended to provide a budget projection estimating the impact of enacting that bill on Medicare expenditures over the next 10 years, based on CBO scoring methods.

Study Overview

Our analysis is structured around three primary components, outlined below.

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[1] https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/guidance-licensed-independent-freestanding-emergency-departments-eds-participate-medicare-and. *States "…the Centers for Medicare & Medicaid Services (CMS) issued critical guidance allowing licensed, independent freestanding emergency departments (IFEDs) in Colorado, Delaware, Rhode Island, and Texas to temporarily provide care to Medicare and Medicaid patients to address any surge."*

[2] Policy & Advocacy — National Association of Freestanding Emergency Centers

[3] https://static1.squarespace.com/static/5589a9e7e4b00d51418b6af6/t/65f4bb9ab6f7e719eb6479a8/1710537626654/NAFEC+Report+Presentation+-+October+2023%5B1%5D.pdf

1. **Modeling Growth in FECs After Medicare Recognition**. We model growth in the number of FECs under three scenarios: a) a static number of FECs, b) a slow growth model and c) a high growth model.
2. **Assessing the Impact on Induced demand for Emergency Care**. We model the impact of the bill on demand for emergency care in two models: a) no induced demand and b) a MedPAC-estimated induced demand.
3. **Estimating Impacts of the bill on Medicare Expenditures.** We project the impact of incorporating FECs into the Medicare care continuum as specified in H.R. 3134. This estimate includes comparing spending under a baseline scenario (without Medicare FEC coverage) and an alternative scenario (with FEC coverage), adjusted for expected enrollment growth and Medicare payment updates over the 10-year window.

Addendum Analyses
In addition to the core budget impact analysis, the report includes two supplemental analyses:

1. **Potential Savings from Averted Inpatient Admissions**. An estimate of the cost savings resulting from avoided hospital admissions for select acute health conditions that could be effectively managed at FECs.
2. **Impact of FEC Expansion in Rural Areas**. An analysis of the impact of a policy option to extend Medicare coverage to FECs in rural areas.

This study builds on prior research examining Medicare's recognition of FECs and differences in Medicare payments between FECs and HBEDs. It expands that work by integrating utilization, cost, and policy modeling to provide a comprehensive, CBO-style budget projection.

Analytical Components and Assumptions

Below we describe the key analytical components of our study in detail.

Impact of Medicare Recognition of FECs on Growth

ASSUMPTIONS

In projecting the potential growth of FECs under H.R. 3134, we make the following assumptions based on anticipated regulatory changes, market demand, and provider behavior in response to Medicare coverage:

1. *FEC expansion is limited to the fifteen states that currently have no Certificate of Need (CON) laws.*

   Currently, 36 of the 50 states plus the District of Columbia have CON laws in place. A CON program is a state regulatory tool that controls the number of health care resources in an area. CON laws require a hospital or health facility to demonstrate community need before establishing or expanding a health care

facility or service.[4] Given this and other limitations placed on CON facilities, FEC expansion during the ten-year budget window considered in this analysis is focused on the fifteen states that currently have no CON laws, as CON states have high barriers to entry for new types of facilities.

2. *A rapid increase in the number of FECs is unlikely due to regulatory and financial barriers.*

   FEC expansion is further constrained as it may take time for state legislatures to enact legislation that would provide state licensure (as required in Section 2799A–1(a)(3)(D) of the *Public Health Service Act* and in H.R. 3134) for FECs. Delays of state licensure are often associated with constrained periods in which state legislatures meet, and hearings to elicit perspectives, including support and opposition, from interested parties. Further time constraints are associated with state licensure requirements, once legislation is enacted. Then potential FEC operators must raise capital, secure sites, build a facility, fully staff it with ER physicians, ER nurses and staff and provide the necessary equipment and licensure. Therefore, a rapid increase in the number of FECs is unlikely to occur during the ten-year budget window and most of the growth would be at the tail end of that window.

3. *Texas and Colorado, the states with the most FECs, may experience growth in FEC certification.*

   Currently, the majority of the FECs are located in Texas (approximately 200) and Colorado (10). There are a limited number of FECs in several other states: two in Arizona, one in South Dakota, and one in Rhode Island. While Mississippi has created a pathway for six FECs in rural areas, none are currently operational. Additionally, Delaware allows the establishment of FECs, but none currently exist as the five freestanding emergency departments are all owned by hospitals and bill under their hospitals' provider number. We included Texas, Colorado, Arizona, South Dakota, Rhode Island, Delaware, and Mississippi in our model and excluded all other states.

GROWTH ESTIMATES

Considering the limited number of states that are likely to initiate new FEC openings in the next ten years and the populations of those states, we estimate that the maximum number of FECs that could possibly be in operation during the ten-year budget scoring window is approximately 600. This estimate is based on the populations in each of the seven states, and an assumed FEC saturation of one FEC per 80,000 people. The calculated FEC saturation for each of the seven states is as below.

- Texas – 364
- Colorado – 72

[4] 50-State Scan of State Certificate-of-Need Programs - NASHP

- Arizona – 89
- Rhode Island – 14
- South Dakota – 11
- Delaware – 12
- Mississippi - 37

The theoretical FEC saturation described above is, however, likely infeasible due to the ten-year window considered, time lags required to enact legislation enabling FEC licensure, and delays associated with building a new facility, staffing it and ensuring all the requirements of operating an ED are met.

Due to these constraints, we assume that 100 FECs will participate in the Medicare program in 2023.[5] We model three different scenarios in our analysis: a) a static number of 100 FECs over the ten-year period, b) a slow growth model of up to 140 FECs by 2035 and c) a high growth model of up to 185 FECs by 2035.

To determine baseline utilization for FECs by severity level in 2026, we annualized the average number of encounters per FECs by severity level for all of 2022 and Q1 of 2023. We assumed that the baseline utilization would change at the same rate as the change in Part B enrollment between 2026 and 2035, as reported in the Medicare Trustees Report. The utilization by severity level were the basis for our current CBO-style analysis as shown in **Exhibit 1** below.

Exhibit 1: Assumed Medicare Beneficiary Encounters in FECs (2026 to 2035)

Severity Level	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
1	8	9	9	9	9	10	11	12	13	14
2	38	39	39	39	39	40	41	42	43	44
3	164	169	168	168	168	171	174	177	180	183
4	126	130	129	129	129	131	133	135	137	139
5	77	79	79	79	79	81	83	84	85	86
Total	**413**	**426**	**424**	**424**	**424**	**433**	**442**	**450**	**458**	**466**

Dobson | DaVanzo Analysis

Impact of Medicare Recognition of FECs on Induced Demand

A primary concern of policymakers when considering recognizing a new type of provider or expanding the scope of services is whether that will result in induced demand through increased utilization. Accordingly, we considered whether permanent Medicare recognition of FEC providers would increase overall utilization of services and corresponding Medicare expenditures associated with potential new demand. In this context, induced demand refers to instances where a beneficiary seeks care at a Medicare-recognized FEC, whereas they would have otherwise foregone care had the FEC not been available.

[5] Note that the some of the 128 FECs identified in 2020 and 2021 that participated in the waiver may have closed or been acquired by hospitals.

This is distinct from substitution, which occurs when a beneficiary chooses to visit an FEC instead of a HBED for care they would have sought regardless. In other words, induced demand leads to an overall increase in emergency care encounters, while substitution shifts the site of care without changing the total number of visits.

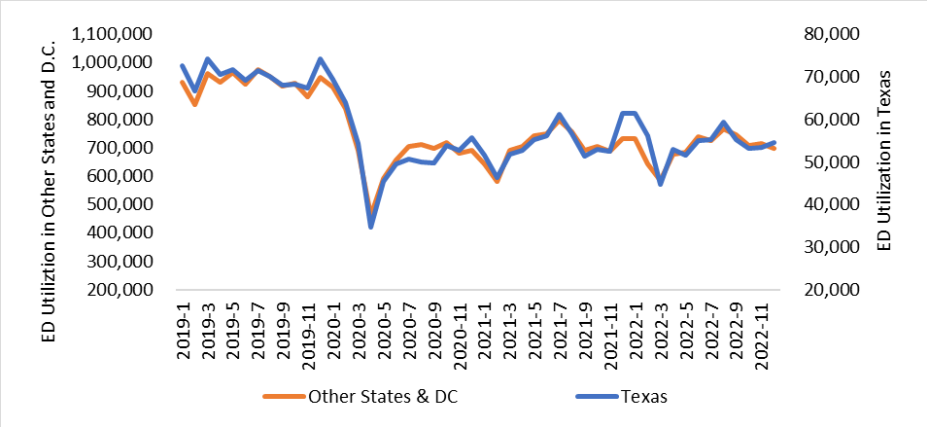
In regard to FEC utilization, a 2023 study conducted by Dobson | DaVanzo on behalf of NAFEC found no evidence of induced demand for ED services associated with Medicare recognition of FECs in Texas during the COVID-19 PHE. We examined induced demand using the two analyses described below.

1. *Comparison of Monthly ED Utilization in Texas vs. Other States and DC.*

In the first analysis, we compared monthly ED utilization (for both HBED and FEC services) in Texas as compared to other states and D.C., between January 2019 and December 2022.

Results from our analysis are shown in **Exhibit 2** below. As shown, trends in ED utilization for Medicare beneficiaries in Texas were very similar to trends for the rest of the country, both pre- and post-PHE.[6] That is, Medicare coverage for FECs under the waiver did not discernably shift demand for emergency services in Texas at a different rate from that experienced in the rest of the country which serves as a comparison group.

Exhibit 2: Trends in ED Utilization in Texas vs. Other States and D.C. (2019 – 2022)



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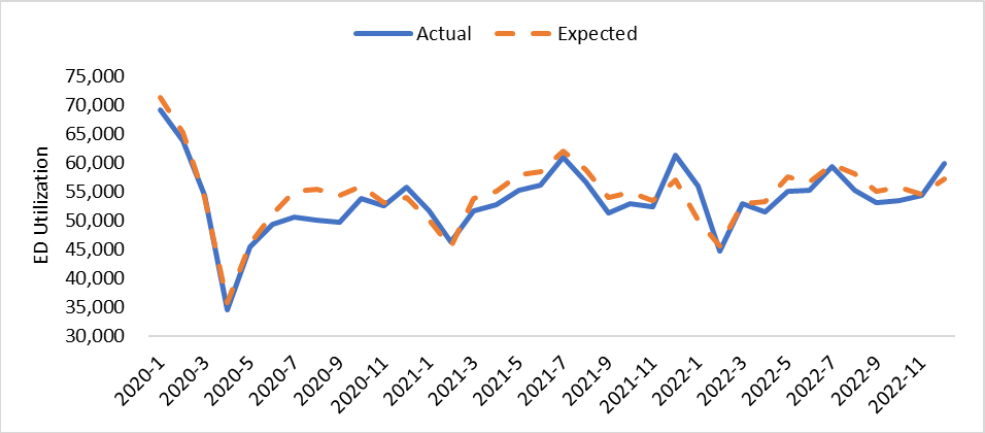
2. *Comparison of Expected vs. Actual Monthly ED Utilization in Texas.*

In the second analysis, we compared the "expected" utilization of emergency services by Medicare beneficiaries in Texas to actual monthly utilization. The expected utilization was

[6] We note that the steep drop-off in the volume of ED claims observed in Texas and the rest of the United States in early 2020 is likely a direct result of the emergence of COVID-19 and the resultant PHE. As the PHE begins to ease, the volumes of ED visits increase in both FECs and HBEDs at approximately the same rate.

calculated by modeling month-over-month baseline utilization of ED services in all other states. Additional details of the methodology are included in **Appendix A**. As illustrated below in **Exhibit 3**, the expected and actual ED utilization patterns in Texas were nearly identical, suggesting that Texas experienced little to no increase in overall ED utilization due to induced demand, following Medicare's recognition of FECs.

Exhibit 3: Expected Versus Actual ED Utilization in Texas (2019 – 2022)



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Projection of the Financial Impacts of the H.R. 3134 on Medicare Expenditures between 2026 and 2035

We determined the future Medicare expenditures associated with Medicare's recognition of FECs in three steps.

1. Quantify Utilization of FECs, based on analyses using Medicare claims data from 2022 to 2023, including beneficiary encounters per FEC by severity level
2. Quantify Medicare Expenditures for Services Delivered at FECs and HBEDs, based on analyses of 2022 and Q1 2023 Medicare claims data.
3. Project Impacts of Medicare's Recognition of FECs Under H.R. 3134 on Medicare Expenditures between 2026 and 2035 using a CBO-type methodology.

Below we describe the steps in detail.

STEP 1: QUANTIFY UTILIZATION OF FECS AND HBEDS USING MEDICARE CLAIMS DATA FROM 2022 TO 2023

We conducted analyses of 100% Medicare claims data from all four quarters of 2022 and the 1st quarter of 2023 (annualized), to determine the current utilization of FECs and

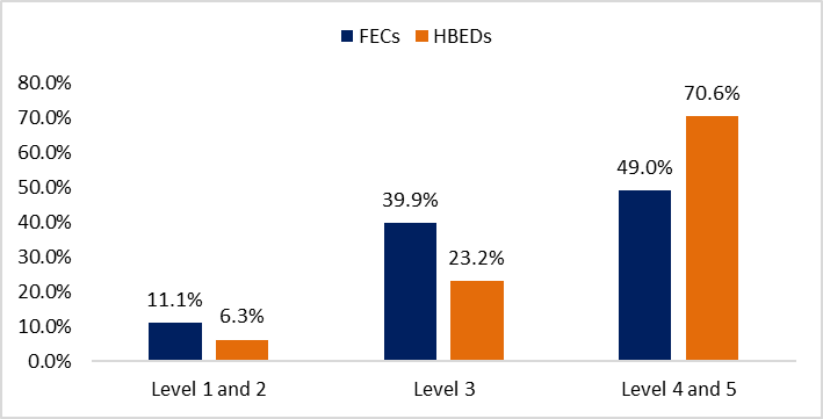
HBEDs. We completed this analysis by severity level using the Common Procedural Terminology (CPT) system.[7]

Although we had data from 2020 and 2021, we chose to exclude that from this baseline as it was significantly impacted by the COVID pandemic, including COVID treatments and testing and interrupted health care demand that impacted health care utilization for all providers across the board.

Baseline ED encounters by severity were identified from Medicare Fee-For-Service (FFS) claims data in 2022, the last complete year of FEC coverage and the first quarter of 2023.[8] These baseline encounters were assessed to identify the average number of annualized services provided to Medicare beneficiaries in the base data. The average Medicare encounter payments by severity level were also calculated for both HBEDs and FECs.

As shown in **Exhibit 4** below, HBEDs treat a higher proportion of the more severe cases (Levels 4 and 5), while FECs treat a higher proportion of the mid- (Level 3) and lower-severity (Level 1 and 2) cases. Overall, both FECs and HBED had a relatively small proportion of level 1 and 2 cases. Specifically, 11.1 percent of cases seen at FECs were Level 1 and 2 as compared to 6.3 percent of cases seen at HBEDs.

Exhibit 4: Distribution of Medicare Claims by Severity Level (FECs compared to HBEDs), 2022-2023



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[7] The following CPT codes were used to determine severity level: Level 1 - CPT 99281: Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making; Level 2 - CPT 99282: Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity; Level 3 - CPT 99283: Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity; Level 4 - CPT 99284: Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity; and Level 5 - CPT 99285: Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity.

[8] Medicare coverage of FECs ended in May of 2023.

Overall, our analyses indicate that FECs treat Medicare beneficiaries at all severity levels, with nearly half (49.0 percent) in severity level 4 or 5.

We applied the results from our analysis to estimate utilization of services by severity level for an average FEC. On average, we determined that an FEC has 413 Medicare encounters per year.

We used the distribution of beneficiaries by severity level in **Exhibit 4** to allocate the average Medicare encounters to each severity level as follows: 8 in level 1, 38 in Level 2, 164 in level 3: 164, 126 in Level 4, and 77 in level 5.

The above average utilization by severity at an FEC is the unit of measure we use to determine changes in Medicare expenditures under each of our models described above and is applied below.

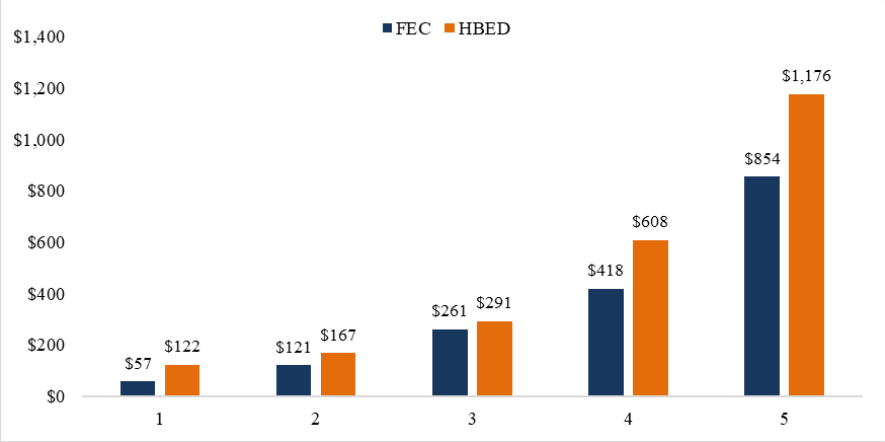
STEP 2: QUANTIFY MEDICARE EXPENDITURES FOR SERVICES DELIVERED AT FECS AND HBEDS USING MEDICARE CLAIMS DATA FROM 2022-2023

Using the 100 percent Medicare Fee-for-Service claims data from all four quarters of 2022 and the 1st quarter of 2023 (annualized), we conducted analyses to determine the differences in current Medicare expenditures at FECs compared to HBEDs.

Overall, our analyses showed that average Medicare payments to FECs are lower than average Medicare payments to HBEDs by case severity level.

The unweighted differences in Medicare payments for beneficiaries seeking care in an ED by severity level are shown in **Exhibit 5** below.

Exhibit 5: Unweighted Average Medicare Payment by Severity Level: FECs Compared to HBEDs



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After standardization by severity level and volume, we found that total FEC Medicare payments are 23.5 percent lower than HBED payments. Our model (detailed below) assumes that payment relationships will remain steady through the ten-year budget window to 2035. This finding is based upon a case-mix weighted average of Medicare payments across all severity levels (level 1 and 2 included). This percentage slightly increases to 25.5 if severity Levels 1 and 2 are excluded from Medicare coverage in FECs but not in HBEDs.

STEP 3: PROJECT IMPACTS OF MEDICARE'S RECOGNITION OF FECS UNDER H.R. 3134 ON MEDICARE EXPENDITURES BETWEEN 2026 AND 2035 USING A CBO-TYPE METHODOLOGY

Using the current utilization and Medicare expenditures obtained from Steps 1 and 2, and additional assumptions on growth in utilization and induced demand, we modeled future Medicare expenditures on FEC and HEBDs between 2026 and 2035 for a baseline (current law) and alternative scenario where H.R. 3134 is enacted. We calculated the financial impact of H.R. 3134 on Medicare expenditures by subtracting baseline HBED payments from the alternative FEC payments each year and then summing the differences across years.

Below we briefly describe the methodology and results. Additional detail on the methodology is included in **Appendix A**.

BASELINE SCENARIO (CURRENT LAW)

In the baseline scenario, we assume that Medicare beneficiaries continue to utilize hospital-based emergency departments (HBEDs) at current levels throughout the 2026–2035 period, under the assumption that Medicare coverage for FECS is not enacted. However, utilization employed in the CBO-style analysis is limited to the number of beneficiaries who would have otherwise sought care at FECs, based on 2022–2023 Medicare claims data.

We assigned the average number of Medicare encounters per FEC, stratified by severity level, and applied HBED Medicare payment rates for each severity level to calendar year 2026. Spending and utilization were then adjusted annually to reflect changes in Medicare Part B enrollment and updates to the Medicare Market Basket, net of assumed productivity adjustments.

Finally, we projected Medicare spending by patient severity under the baseline scenario across the full ten-year budget window.

ENACTMENT OF HR 3134 SCENARIO

Enactment of H.R. 3134 would ensure that FECs are recognized by Medicare. Projecting Medicare spending by severity for beneficiaries substituting FECs for HBEDs over the ten-year period with additional assumptions and scenarios is described below.

1. *FEC Payments under H.R. 3134 are Limited to Level 3-5 Cases*

FECs Level 1 and 2 services account for 11.1 percent of FEC encounters for Medicare beneficiaries and 6.3 percent of HBED beneficiaries. Some policymakers have expressed concern that some low acuity patients may associate FECs, despite full ER capability on-site (with ER physician on premise 24/7, advanced imaging, diagnostics and lab) with an urgent care clinic (typically open only 9 to 5, staffed by nurse practitioner, and without having the equipment or capabilities as an FEC). To address this concern, the bill excludes FEC facility coverage of acuity levels 1 and 2 by identifying "specified emergency services furnished by an emergency center" as those associated with Levels 3, 4 and 5. That is, the bill would not recognize Level 1 and 2 services for Medicare facility reimbursement purposes (though professional services offered by physicians would still be eligible as they would at an urgent care clinic). Our analysis is based on this policy proposal as specified in the legislation.

2. *Induced Demand Modeled Under Two Separate Models*

Although our 2023 study on the impact of FEC participation in the Medicare program during the PHE (2020-2022) indicated that *there was no measurable induced demand*, other more dated studies in literature on hospital-owned off campus emergency departments have indicated the possibility of induced demand for ED utilization.

Specifically, in its June 2017 *Report to the Congress,* MedPAC reported an increase in the growth of ED utilization in areas with high numbers of stand-alone emergency facilities owned by hospitals (or HEBDs), which MedPAC referred to as Off-Campus Emergency Departments (OCEDs), as compared to areas with no HBEDs. The MedPAC report provides a benchmark for induced demand, although it may not be entirely generalizable to FECs, as it did not examine FEC participation in Medicare because they were not recognized by Medicare during that period. We also note that an OCED provides a referral source to its hospital's main campus. MedPAC's analysis was based upon the seven Metropolitan Statistical Areas (MSA) with the highest share of hospital-owned and operated HBEDs. MedPAC found that between 2010 and 2014 overall utilization in OCED increased 5.5 percent while HBED utilization increased 0.4 percent. The difference is attributed by MedPAC to the induced effect of OCED availability.[9]

[9] MedPAC Report to Congress. Chapter 8: Stand-alone emergency departments (June 2017 report).

Given the possibility of induced demand, we developed two models, one with no induced demand – consistent with our findings of FEC participation in Medicare during the PHE -- and one incorporating the MedPAC proxy of an increase in ED utilization of 5.1 percent.[10] The number of Medicare beneficiaries by severity level and the Medicare payment by severity (from Step 1 and 2) were assigned to calendar year 2026, the assumed first year of Medicare recognition of FECs following enactment of H.R. 3134.

3. FEC Growth Modeled Under Three Scenarios

For each of these models, we also assessed the impacts of a static number of FECs at 100 per year,[11] a slow growth in number of FECs from 100 in 2026 to 140 in 2035, and a high growth in the number of FECS from 100 in 2026 to 185 in 2036. The slow and high growth models were developed in consultation with key informants from NAFEC.

To determine the impact of enactment of H.R. 3134 on Medicare Expenditures, we calculated the difference in spending between the baseline and alternative scenarios.

Results

Model 1: No Induced Demand

In **Exhibit 6,** we show savings to Medicare for the model without induced demand for the three modeled scenarios of FEC growth. The savings are derived from two sources: 1) the 25.5 percent lower cost per severity adjusted patient and 2) the disallowance of levels 1 and 2 FEC payments in FECs. We found that savings were substantial at each level of acuity, as shown above in Exhibit 4, and we understand that these savings are associated with fewer tests and procedures ordered for patients at FECs. The reason for this lower spending per beneficiary is not due to different payment rates (as they were identical) and is outside the scope of our analysis. The non-induced demand model produces savings because the average utilization of services and procedures, and therefore the Medicare payment within each severity level is lower in FECs than in HBED. As a result, the substitution of lower ED spending in an FEC reduces expenditures relative to those in an HBED. We attribute utilization of FECs to a market shift from HBEDs, which is consistent with utilization of ED services in Texas during the PHE observed in our prior study, where there was no statistical increase in utilization of ED in Texas as compared to the rest of the country.

There are two components of savings: 1) Non-Medicare coverage for low acuity patients (level 1 and 2 services); and 2) lower utilization of services and Medicare payments for severity levels 3-5. Assuming no growth in the number of FECs during the 10-year budget

[10] We use the MedPAC analysis as a benchmark for any induced demand associated with FEC recognition because OCEDs are not physically connected to hospitals. The primary difference is that OCEDs, are owned by hospitals while FECs have no financial relationship to a hospital.

[11] While our prior study identified 128 FECs participating between 2019 and 2022, we identified 100 participating in Medicare during 2022.

window, our analysis showed Medicare savings total $83.3 million, of which $7.1 million is attributable to non-coverage of levels 1 and 2 services and the rest attributable to lower spending per patient for acuity levels 3-5. The savings increased to $101.1 million under the slow growth model and $120.8 million under the high growth model. The portion of the savings attributable to lower Medicare expenditures for level 3-5 services in FECs ranged between $76.2 and $110.4 and the portion attributable to non-coverage of Medicare payments for Level 1 and 2 services ranged from $7.1 million to $10.3 million depending on the assumed FEC growth rate.

Exhibit 6: 10-year Impact of H.R. 3134 with No Induced Demand for ED Services

Assumed Growth in FECs	Savings from Lower Cost of Care in FECs	Savings from No Coverage for Level 1 and 2 Care	Total Ten-Year Medicare Savings
Static	$76,151,486	$7,100,781	$83,252,267
Slow	$92,483,156	$8,649,022	$101,132,178
High	$110,417,927	$10,348,481	$120,766,408

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Model 2: Induced Demand

Exhibit 7 summarizes the impact associated with Medicare beneficiaries substituting FEC care for HBED care along with a 5.1 percent induced in demand associated with the new availability of FECs. As expected, the induced demand reduces the calculated savings estimates.

Assuming no growth in the number of FECs during the 10-year budget window, Medicare coverage of FECs will result in $68.6 million in savings to Medicare. Estimated savings increased to $83.3 million under the slow growth model, and $99.5 million under the high growth model. The savings attributable to lower Medicare expenditures in FECs ranged between $61.5 and $89.2 million and that attributable to Medicare not covering Level 1 and 2 services in the model with no induced demand are identical as the model with induced demand.

Exhibit 7: 10-year Impact of H.R. 3134 with the MedPAC Predicted Induced Demand

Assumed Growth in FECs	Savings from Lower Cost of Care in FECs	Savings from No Coverage for Level 1 and 2 Care	Total Ten-Year Medicare Savings
Static	$61,493,377	$7,100,781	$68,594,158
Slow	$74,682,777	$8,649,022	$83,331,799
High	$89,166,790	$10,348,481	$99,515,271

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Addendum: Supplemental analyses

Potential Savings from Averted Inpatient Admissions

HBEDs and/or hospital affiliated OCEDs have different patterns of inpatient admissions from FECs. We note that results from a previous 2017 study comparing inpatient admission rates for select chronic conditions in HBEDs versus freestanding EDs showed lower admission rates for similar patients in FECs than did HBED. Specifically, patients with a presenting diagnosis for chest pain, COPD, asthma and CHF in HBEDs were 20 percent more likely to be admitted to the hospital than a similar patient presenting in a freestanding ED.[12] Unlike HBEDs or OCEDs owned by hospitals, FECs have no economic incentive to admit patients.

METHODOLOGY

To assess the potential impact of avoided inpatient admissions on Medicare expenditures due to increased access to FECs, we conducted analyses of Medicare claims data from 2022 to 2023[13] for beneficiaries receiving care in FECs and HBEDs. We examined the discharge status of ED encounters for those with a primary diagnosis of COPD, CHF or chest pain within states likely to experience FEC expansion,[14] to compare the differences in inpatient admissions for beneficiaries receiving care in FECs vs. HBEDs and obtain baseline utilization patterns.

To calculate the impact of potentially avoidable inpatient admissions on Medicare expenditures due to FEC expansion, we determined the difference in the average payment for an HBED visit resulting in an admission and an FEC visit with no admission and then multiplied that amount by the estimated number of avoidable inpatient admissions for beneficiaries using FECs. We assumed that 20 percent of inpatient admissions following a visit to an HBED are avoidable.[15] We applied the same population growth and payment updates as in the CBO-score, to determine the Medicare payments for theoretically avoidable admissions between 2026 and 2035.

It should be noted that our utilization estimate is tied to the change in the projected Part B population. Specifically, utilization was modeled to change at the same rate of the projected Part B enrollment change, as detailed in the 2024 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust

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[12] Simon, E. L., Dark, C., Kovacs, M., Shakya, S., & Meek, C. A. (2018). Variation in hospital admission rates between a tertiary care and two freestanding emergency departments. The American journal of emergency medicine, 36(6), 967–971. https://doi.org/10.1016/j.ajem.2017.10.066.

[13] Our analysis begins with Medicare claims data from 2022 and the first quarter of 2023 in states that are likely to see FEC expansion.

[14] Texas, Colorado, Arizona, Rhode Island, South Dakota, Delaware and Mississippi are the states identified above as likely FEC expansion states.

[15] We based this assumption on findings from Simon et. al.

Funds. Although per capita utilization might be expected to increase as Medicare beneficiary acceptance and utilization of FECs increase over time. As there are limited data sources from which to benchmark utilization change, we held utilization constant. As average FEC payments are lower than HBED payments at all severity levels, assumptions of increased substitution of FEC services for HBED services, we believe that our approach is conservation. That is, Medicare savings from our model would be conservative if there is increased per capita utilization.

RESULTS

Exhibit 8 shows the number and percentage of claims by discharge destination and chronic condition. As shown, across all chronic conditions 7 percent fewer Medicare beneficiaries are admitted to the hospital after presenting in an FEC as compared to an HBED. The results varied by chronic condition. 31 percent fewer Medicare beneficiaries are admitted to the hospital when presenting in an FEC with COPD as compared to an HBED, while beneficiaries with CHF and Chest pain receiving care in an FEC have slightly higher admissions than an HBED. Given the descriptive nature of our analyses, we used estimates from Simon et al. to calculate the impact on Medicare expenditures, as they conducted a multivariate logistic regression that adjusted for various confounding factors to show that FECs had 20 percent fewer inpatient admissions compared to HBEDs.

Exhibit 8: Discharge Status of Medicare Beneficiaries with a Primary Diagnosis of Select Chronic Conditions in FECs vs. HBEDs in Select States[16]

Diagnosis	Discharge Destination	FECs		HBEDs	
		Number of Claims	Percent	Number of Claims	Percent
COPD	Discharged to home or self-care	330	91%	18,883	57%
	Admitted to inpatient hospital	31	9%	13,099	39%
	Other	-	0%	1,374	4%
	Grand Total	**361**	**100%**	**33,356**	**100%**
CHF	Discharged to home or self-care	79	64%	31,812	63%
	Admitted to inpatient hospital	45	36%	12,820	25%
	Other	-	0%	6,213	12%
	Grand Total	**124**	**100%**	**50,845**	**100%**
Chest Pain	Discharged to home or self-care	1,372	86%	91,142	88%
	Admitted to inpatient hospital	135	8%	7,079	7%
	Left Against Medical Advice	73	4%	3,490	3%
	Other	14	1%	2,348	2%
	Grand Total	**1,594**	**100%**	**104,059**	**100%**

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[16] Texas, Colorado, Arizona, Rhode Island, South Dakota, Delaware and Mississippi are the states identified above as likely FEC expansion states.

Exhibit 9 shows the estimated impact of potentially avoidable inpatient admissions on Medicare expenditures.

Exhibit 9: Impact of Avoidable Hospital Inpatient Admissions for Beneficiaries in HBED Following FEC Expansion

Diagnosis	Average Medicare Payment for HBED visit with admission (A)	Average Medicare Payment for FEC visit with no admission (B)	Total Inpatient Admissions after HBED[17] (C)	Avoidable Inpatient Admissions (0.2 x C)	Total Medicare Expenditures for Avoidable Inpatient Admissions (2026)[18]
COPD	$9,036	$668	12,090	2,418	$16,231,056
CHF	$13,905	$805	5,626	1,125	$11,824,769
Chest Pain	$4,993	$680	4,744	949	$3,283,629
TOTAL					**$31,339,454**

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Our analysis shows that the average payment for a Medicare beneficiary who presents in an HBED with a primary diagnosis of COPD and is admitted to a hospital is $9,036. Multiplying that by 20 percent of admissions translates to savings of $16.2 million in annualized dollars in 2026 and $229.3 million over the ten-year timeframe due to averted admissions for beneficiaries receiving care in FECs.

Similarly, averted admissions for beneficiaries with CHF translate to savings of $11.8 million in annualized dollars in 2026 and $167.1 million over the ten-year timeframe and for beneficiaries with a primary diagnosis of chest pain translate to $3.3 million in annualized dollars and $46.4 million over the ten-year timeframe.

Impact of Medicare Coverage for Rural FECs

We also examined the impact of an alternative proposed policy that would only allow Medicare coverage of FECs in rural areas that are 35 miles or a 15-minute drive from a hospital.

METHODOLOGY

To model the impact of this proposed policy, we created a list of select inpatient hospitals using the 2024 Provider of Services File (POS). We flagged for inclusion the following provider types: short-term acute care hospital, critical access hospital, or rural emergency

[17] The total inpatient admissions following an HBED visit displayed in this table are different than in Exhibit 7 because, in Exhibit 8, we limit the analysis to an admission to the same hospital's inpatient unit as the HBED. In Exhibit 7, beneficiaries could have been admitted to a different hospital following the HBED visit.

[18] To calculate total expenditures for avoidable inpatient admissions, we multiply the difference in payments for an HBED visit with an admission and an FEC visit with no admission by 20 percent of the total inpatient admissions after an HBED. We then multiply the result by 455/365 to annualize the results since the data are collected over Q1 2022 to Q3 2023—5 quarters. The formula for the calculation is [(A-B)* (0.2 x C)] x 455/365.

hospitals. Any hospitals with a past termination date as identified from the POS file were excluded from the analysis. A total of 4,529 hospitals were included in the analysis after applying these exclusion criteria.

We then used the US Census Geocoder to geocode providers, using the hospital address in the POS file. Providers that were unable to be geocoded via the Census Geocoder were geocoded manually using Google Maps longitude and latitude coordinates.

Maptitude is a user-friendly GIS software that helps users create, analyze, and visualize maps and spatial data. For this analysis, we used Maptitude to map the geocoded providers and create drive-distance rings of 35 miles from each of the 4,529 providers. Given the close proximity of some providers, these drive-distance rings were collated into one layer, creating a single drive-distance ring encompassing all providers in the country. Maptitude's overlay feature was then used to determine the total Medicare population more than 35 miles from a provider. The combined drive-distance ring was overlayed with every ZIP Code in the United States, generating a percentage overlap between the ZIP Code boundaries and the drive-distance ring. The percentage of a ZIP Code not overlapped by the drive-distance ring was then multiplied by the ZIP Code population to estimate the population more than 35 miles from a provider. These population estimates were then aggregated at the state level.

The population in states that are likely to expand FEC availability during the time frame that meets the rural limits was approximately 734,450.[19] If the saturation level of EDs is about 1 per 80,000, then there will be room for approximately 9 new FECs in total in these states under this rural provision.

We then applied the same model and assumptions regarding growth of new FECs and induced demand that we used above with the assumption that the 9 rural FECs are in operation in 2026, as summarized below. We assumed that in the slow growth model, there will be 12 rural FECS by 2035 and in the high growth model there will be 14 rural FECs by 2035.

Exhibit 9 shows the savings associated with Medicare beneficiaries substituting FEC care for HBED care in rural areas not served by a hospital.

Assuming no growth in the number of FECs during the 10-year budget window, the impact of 9 FECs opening in rural areas is estimated to be $7.5 million in savings. Assuming slow FEC growth, savings are approximately $8.6 million and assuming high FEC growth, savings are $9.4 million. The portion of savings attributable to lower Medicare expenditures in FECs ranged between $6.9 and $8.6 million while the portion attributable

[19] Texas, Colorado, Arizona, Rhode Island, South Dakota, Delaware and Mississippi are the states identified above as likely FEC expansion states.

to Medicare not covering severity Levels 1 and 2 services ranged from $0.6 million to $0.8 million, depending on the assumed growth rate of FECs, as summarized in **Exhibit 10**.

Exhibit 10: 10-year Impact of Policy Allowing Medicare Coverage of FECs in Rural Areas with No Induced Demand for ED Services

Assumed Growth in FECs	Savings from Lower Cost of Care in FECs	Savings from No Coverage for Level 1 and 2 Care	Total Ten-Year Medicare Savings
Static	$6,853,634	$639,070	$7,492,704
Slow	$7,842,290	$733,024	$8,575,314
High	$8,576,465	$802,675	$9,379,140

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Exhibit 11 details the savings associated with Medicare beneficiaries substituting FEC care for HBED care in rural areas not served by a hospital and applies a 5.1 percent increase in demand associated with the new availability of FECs.

In the model where we assumed no growth in the number of FECs during the 10-year budget window, we calculated savings of $6.2 million. In the slow growth model, savings are $7.1 million and in the high growth model savings are $7.7 million. The portion of savings attributable to lower Medicare expenditures in FECs ranged between $5.5 and $6.9 million while the portion attributable to Medicare not covering severity Levels 1 and 2 services was the same as the results from the non-induced demand model.

Exhibit 11: 10-year Impact of Policy Allowing Medicare Coverage of FECs in Rural Areas with MedPAC Predicted Induced Demand for ED Services

Assumed Growth in FECs	Savings from Lower Cost of Care in FECs	Savings from No Coverage for Level 1 and 2 Care	Ten-Year Medicare Savings
Static	$5,534,404	$639,070	$6,173,474
Slow	$6,332,850	$733,024	$7,065,874
High	$6,925,765	$802,675	$7,728,440

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Conclusion

In summary, our prior 2023 study of the Medicare claims file demonstrated that recognition of FECs during the PHE did not increase demand, while delivering care at about 21% savings on a risk-adjusted basis during that period. This study shows that even under a modest increase in utilization (induced demand), the enactment of H.R. 3134 is projected to yield approximately 25% in Medicare savings, ranging from $68.6 million to $120.8 million over ten years. The portion of these savings attributable to the lower Medicare costs in FECs is between $61.5 and $110.4 million.

Further savings ranging from $46 to $229 million could be realized from potentially avoidable hospital admissions for beneficiaries using FECs. In a limited policy option where Medicare coverage is only extended to FECs in rural areas that are 35 miles or a 15-minute drive from a hospital, additional savings ranging from $6.2 to $9.4 million could be realized.

Appendix A: Study Methodology

Overall Approach to CBO Scoring

BASELINE UTILIZATION & PAYMENTS

To assess baseline utilization, Medicare claims from the Limited Data Set (LDS) were extracted, based on Revenue Center (045x: Emergency Room) or Place of Service (POS) Code (23: Emergency Room). The Month-by-month rate of FEC usage was calculated for the by month for January 2022 through March 2023). The average utilization by severity level was calculated for each month by dividing the total utilization by severity for each of the months by the number of FECs that provided those services in each month. To calculate average Medicare FEC utilization by severity level, total Medicare encounters for all four quarters of 2022 and the first quarter of 2023 were grouped by severity level and annualized to represent one year.

To calculate average Medicare payment by severity level and by site of service, total Medicare payments for all four quarters of 2022 and the first quarter of 2023 were grouped by severity level, summed separately for HBEDs and FECs, and annualized to represent one year. These annualized and averaged payments by severity level were divided by the number of services (again annualized and averaged) by severity level by the respective site of service, HBED or FEC. Average 2022 HBED and FEC payments by severity were adjusted for change in payment using actual Medicare payment updates and forecasts, assuming a 0.5 percentage point productively adjustment, through 2035, with 2035 assumed to be the same as 2034.

NUMBER OF FECS

To identify the number of FECs, Provider Numbers from the 2022 and first quarter of 2023 claims data were analyzed to identify HBEDs and FECs. Specifically, provider numbers that identified the provider as (1) Short-Term Acute Care Hospitals or Critical Access Hospitals and (2) providers in Texas were retained for further analysis. FECs were identified from this subset by (1) exclusion of hospitals included on the IPPS Impact File and (2) manual reviews. In 2022, 100 FECs were identified.

UTILIZATION CHANGE DUE TO POPULATION

To model the impact of the population change on utilization, projected Part B enrollment was selected from the 2024 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

UTILIZATION CHANGE SUPPLIER-INDUCED DEMAND

To consider increased utilization due to the increased availability of emergency services, analysis from the Medicare Payment Advisory Commission (MedPAC) was selected. In the June 2017 *Report to the Congress*, MedPAC indicated that the utilization of ED services between 2010 and 2014 increased 5.5 percent for the seven metropolitan statistical areas (MSAs) with the highest rates of off-campus emergency departments (OCEDs) compared to an increase of 0.4 percent in eleven comparable MSAs with no OCEDs. The percentage point difference of 5.1 percent (5.5 percent minus 0.4 percent) is used as proxy for increased utilization from supplier-induced demand.

CBO SCORE

To determine baseline Medicare payments per year, the modeled HBED payment by severity each year was multiplied by the average FEC utilization by severity each year, less an adjustment for assumed supplier-induced demand. To determine the alternative scenario of Medicare payment with FEC recognition, the modeled FEC payment by severity each year was multiplied by the average FEC utilization by severity each year, with no adjustment for assumed supplier-induced demand. The Score was calculated by first subtracting the baseline HBED payments from the alternative FEC payments each year and then summing the differences across years.

Overall Approach to Actual vs Expected Analysis

ACTUAL UTILIZATION

To assess actual utilization, Medicare claims from the Limited Data Set (LDS) were extracted, based on Revenue Center (045x: Emergency Room) or Place of Service (POS) Code (23: Emergency Room). Month-by-month, outpatient only emergency department usage for encounters was calculated from January 2019 through December 2022 for urban HBEDs and FECs in Texas. These data were used to assess if Texas Medicare ED utilization patterns between January 2019 and December 2022 were consistent with the Medicare ED utilization pattern across the U.S.

EXPECTED UTILIZATION

To assess expected utilization, a benchmark month-over-over month change in ED utilization was calculated using the change in ED encounters for all states and DC, except for Texas. Expected utilization for Texas was calculated for February 2019 first multiplying total Texas ED encounters in January 2019 by the benchmark January-to-February 2019 change in ED utilization for all states and DC, expect for Texas. The calculated expected February 2019 ED utilization and all subsequent months were multiplied by the benchmark changes for each respective month.