Medicare policy issues related to non-urgent and emergency care

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MEDPAC

Context: Concerns related to hospital emergency departments (ED)

Topic 1: Non-urgent care at hospital EDs

- Medicare per beneficiary use of ED services increased 14 percent, versus 4 percent for physician office visits (2011 to 2016)
- Medicare payments to EDs higher than urgent care centers (UCCs)

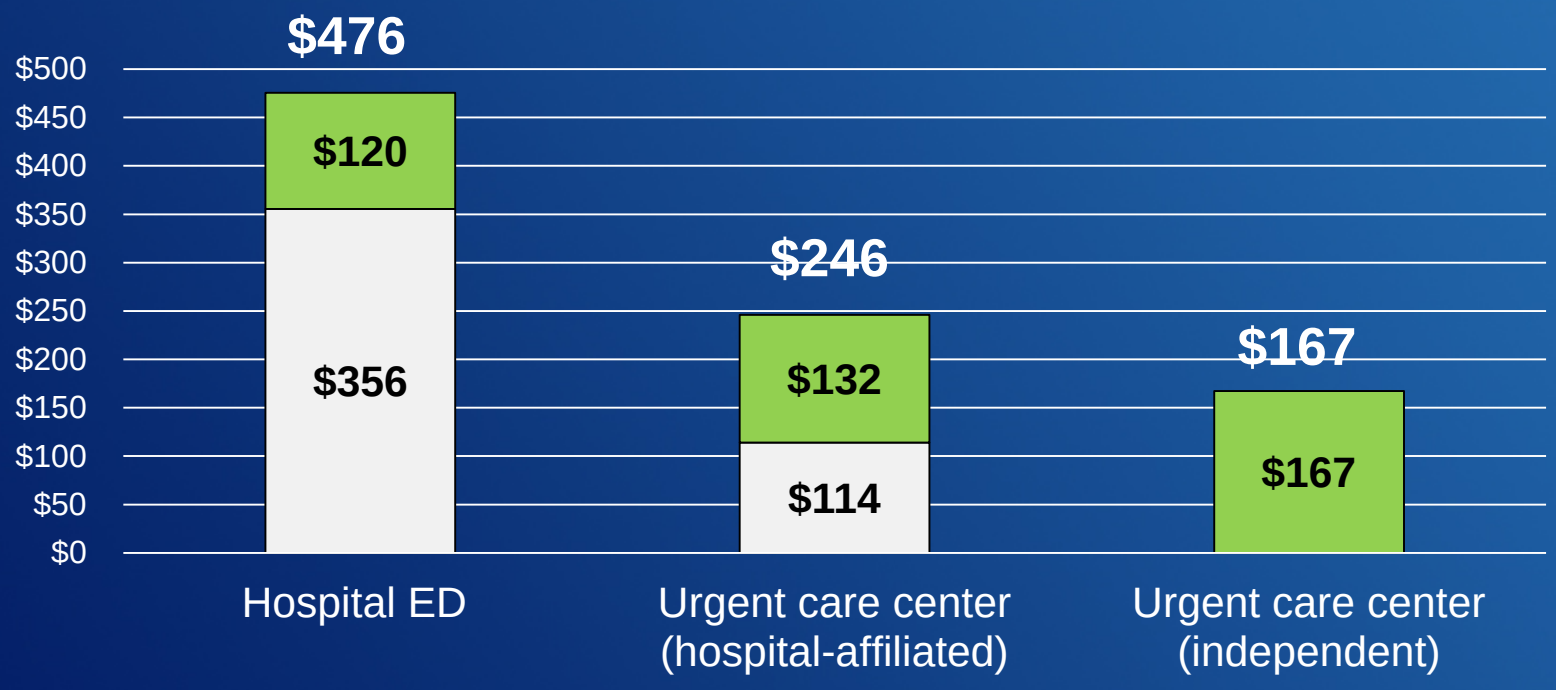
Topic 2: Trends in hospital ED coding

- Medicare spending on hospital outpatient ED services increased 68 percent per beneficiary (2011 to 2016), faster than ED service use
- Faster growth in claims with highest-level ED codes

Background: Urgent care centers

- 8,100 facilities
- 33 percent increase in facilities (2013-2018)
- Independent (2/3) and hospital-affiliated (1/3)
- Basic care, some procedures, x-ray, some labs
- 67 percent commercial patients, 8 percent Medicare
- Medicare use low, but rapid growth
  - 3.2 million physician E&M claims, or 1 percent of total (2017)
  - 73 percent increase in claims per beneficiary (2013-2017)
- Most common beneficiary conditions: Upper respiratory infection (URI), bronchitis, cough, urinary tract infection (UTI), sinus infection
- Payment: Independent = physician claims, hospital-affiliated = physician and facility claims

Illustration: 2018 Medicare payments to EDs for a level-4 visit and comparable payments to UCCs



Note: ED rates reflect an OPPS level-4 ED visit and a PFS level-4 ED visit receiving the facility-based rate. Provider-based UCC rates reflect an OPPS outpatient clinic visit and a PFS level-4 non-facility-based E&M visit for new patients. Independent UCC rates reflect a PFS level-4 facility-based E&M visit for new patients.
Source: MedPAC analysis of the Medicare hospital outpatient prospective payment system and physician fee schedule

Non-urgent care

- Overlap at UCCs and EDs: 8 of 20 most common conditions
- Non-urgent care*: Claims with any of 7 conditions as the principal diagnoses (URI, UTI, bronchitis, contusion, sprain, back pain, arthritis)
- 15 million physician claims for non-urgent care across all settings, 8 million beneficiaries (2017)
  - 11.5 million at physician offices
  - 1.5 million at EDs
  - 790,000 at UCCs
- Growth in claims involving non-urgent care (2013-2017)
  - 72 percent increase per beneficiary at UCCs, 9 percent at EDs

* Corwin, GS. 2016. Site of treatment for non-urgent conditions by Medicare beneficiaries. American Journal of Medicine. September.

Results are preliminary and subject to change

Non-urgent care at hospital EDs

- 1.5 million claims for non-urgent care at EDs (2017)
- 7 percent of all physician ED claims
- Beneficiaries with claims for non-urgent care at EDs appear more complex than beneficiaries with claims for non-urgent care at UCCs, on average

Place of service	Risk score (mean)	Number of chronic conditions (mean)	Share 75 years or older
ED	1.61	3.1	40 percent
UCC	0.97	2.0	29 percent

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Subset of non-urgent claims for beneficiaries treated at EDs may be appropriate for UCCs

- Claims for non-urgent care at EDs where the beneficiary's risk score was 0.97 or lower, and had 2 or fewer chronic conditions
- 500,000 claims for beneficiaries receiving non-urgent care at EDs had similar clinical profiles as those receiving non-urgent care at UCCs (2017)
- 33 percent of all claims for non-urgent care at EDs
- 2 percent of all physician ED claims
- Medicare paid $1 billion to $2 billion more in 2017 because these beneficiaries were treated at EDs, rather than UCCs

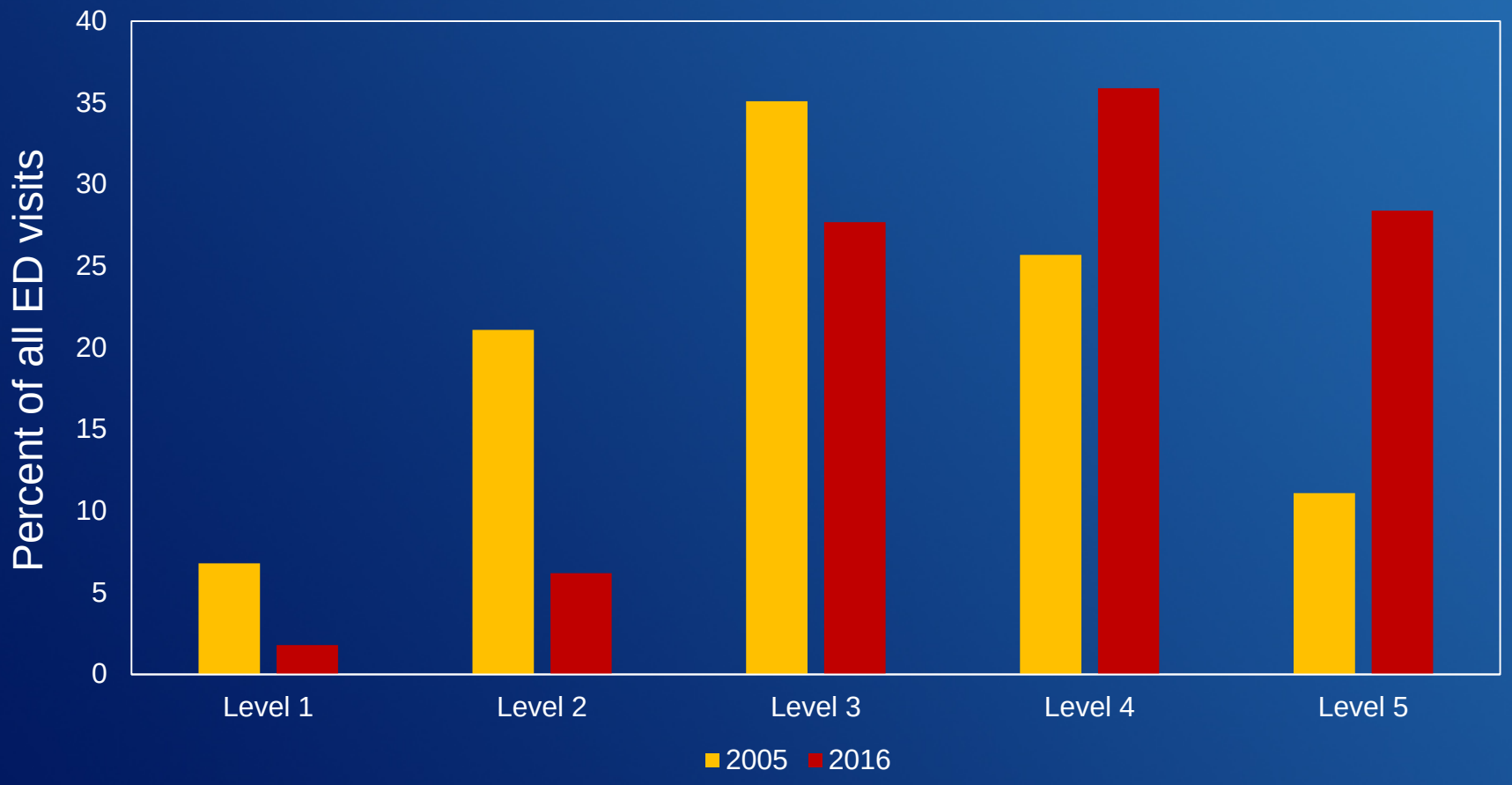
Addressing non-urgent care at EDs

- Commercial insurers:
  - Responding to increased ED costs with retrospective audits and patient education efforts
  - Retrospective audits negatively received by public/media
  - Aetna patients decreased use of EDs for non-urgent care, increased use of UCCs, from 2008 to 2015 (Poon 2018)
- Commission might consider:
  - Patient education campaign about ED/UCC decision
  - Expanding quality measurement for avoidable ED use
  - Encouraging hospital EDs to coordinate care with primary care providers

Trends in hospital ED coding

- Hospitals code each ED visit into 1 of 5 levels; reflect different levels of expected resource use
- Payments increase with the level
- National guidelines for coding ED levels are not used; hospitals use internal guidelines

Coding of ED visits has shifted to higher levels



Source: MedPAC analysis of cost-statistics files from CMS.

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Shift to higher levels for ED visits may have occurred for two reasons

- Clinical attributes of ED patients may have changed
  - ED patients might have more conditions requiring substantial resources
  - Within conditions, patient severity might have increased
- Hospitals might be coding patients with similar clinical attributes to higher levels (upcoding)

Data suggest upcoding may have occurred

- Little change in conditions treated in EDs
- Unlikely that patient severity changed enough to explain change in ED coding

Little change in conditions treated in EDs

- Identified 210 most frequently coded principal diagnoses from 2011
  - Principal diagnosis on 75 percent of ED claims in both 2011 and 2016
  - For most of these 210 diagnoses, share of total changed very little from 2011 to 2016
- Despite little change in conditions treated, share of ED visits coded as level 5 increased from 21% to 28%

Results are preliminary and subject to change

Unlikely patient severity changed enough to explain change in ED coding

- Explored whether migration from EDs to UCCs could explain coding to higher levels in EDs
- From 2013 to 2016, UCC visits increased by 1 million
- If entire increase in UCC visits is low-acuity patients shifting from EDs, not enough to explain increase in ED visits coded at level 5

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Options for addressing ED upcoding

- Single code for all ED visits
- Continue to use multiple levels, but create national guidelines for coding, with attention to incentives for upcoding
  - Current guidelines defined internally by hospitals
  - National guidelines would provide consistent basis for assessing coding practices

Single code for all ED visits

- Advantages:
  - No opportunities for upcoding
  - Simple to implement and use
- Disadvantage:
  - Hospitals that have a high share of high-acuity patients may be disadvantaged

Establish national guidelines for multiple codes

- Advantages:
  - More equitable for hospitals that have high-acuity patients
  - Consistent basis for assessing and auditing coding practices
- Disadvantages:
  - Resources would be needed to monitor for upcoding
  - Hospitals would have to expend resources to determine level for each ED visit

CMS has considered both alternatives

- Proposed single code for ED visits for 2014
  - Listed many benefits of this approach, including prevention of upcoding
  - Met with strong opposition, including the Commission
- Considerable effort to establish multiple codes with national guidelines
  - Involved many entities: AHA, AHIMA, ACEP
  - Despite support from stakeholders, CMS did not implement, citing complexity

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Note: AHIMA (American Health Information Management Association); ACEP (American College of Emergency Physicians)

Discussion

- Urgent care centers
- Non-urgent care claims at hospital EDs
- Hospital ED coding
  - Pursue further work on upcoding
  - Seek Commission guidance on establishing national guidelines