Medicare policy issues related to non-urgent and emergency care

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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

- **Hospital ED**: $476
- **Urgent care center (hospital-affiliated)**: $246
- **Urgent care center (independent)**: $167

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<th>Hospital ED</th>
<th>Physician fee schedule payment rate</th>
<th>Hospital outpatient prospective payment system rate</th>
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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.

Results are preliminary and subject to change.
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
  - 72 percent increase per beneficiary at UCCs, 9 percent at EDs


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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

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

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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.

Results are preliminary and subject to change.
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

Results are preliminary and subject to change
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

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