

Options for slowing the growth of Medicare fee-for-service spending for emergency department services

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Outline of presentation

- Urgent care centers (UCCs): Additional information
 - Quality of care at UCCs
 - Geographic variation in use of UCCs and emergency departments (EDs) for non-urgent care
- Policy options to address non-urgent care at EDs
- Policy options to address hospital ED coding

Background: Urgent care centers

- Urgent care center (UCCs): Health care organization that provides care on a walk-in basis beyond normal business hours and offer basic medical care and imaging services
- Most common conditions treated at UCCs: Upper respiratory infection (URI), bronchitis, cough, urinary tract infection (UTI), sinus infection
- 8,100 UCCs in 2018: 33 percent increase from 2013
- 73% increase in UCC claims per beneficiary (2013-2017)
- 7 percent of fee-for-service (FFS) beneficiaries treated at UCCs in 2017
- Greater use of nurse practitioners and physician assistants than EDs
- Medicare pays less for similar patients at UCCs compared to hospital EDs

Quality of care at UCCs is unclear

- Qualifying clinicians at UCCs participate in the Quality Payment Program used by physicians, no facility-specific program for UCCs
- Research on UCC quality limited: some evidence suggests UCCs prescribe antibiotics more frequently than other providers

Geographic variation in use of UCCs and EDs for non-urgent care

- Non-urgent care*: Claims with any of 7 conditions as the principal diagnosis (URI, UTI, bronchitis, contusion, sprain, back pain, arthritis)
- 15 million physician claims for non-urgent care across all settings
- Geographic variation analysis
 - Use of UCCs is low, with some variation across markets
 - Markets with a higher concentration of UCCs have a larger share of UCC claims for non-urgent care and lower share of ED claims
 - Evidence of UCC visits substituting for ED visits is inconclusive; relationship complicated by induced demand and presence of other non-ED settings

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

Identifying ED claims for non-urgent care appropriate for UCCs

- Overlap at UCCs and EDs: 8 of 20 most common conditions
- 1.5 million claims for non-urgent care at EDs in 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
 - Higher average risk score (1.61 vs. 0.97)
 - Higher average number of chronic conditions (3.1 vs. 2.0)
 - Higher share of patients 75 years or older (40 percent vs. 29 percent)

Some beneficiaries seeking non-urgent care at EDs may be appropriately treated in UCCs

- ED claims for non-urgent care where the beneficiary's risk score was 0.97 or lower, and had 2 or fewer chronic conditions
- As many as 500,000 ED claims (2 percent of all physician ED claims)
- Medicare paid as much as \$2 billion more in 2017 because these beneficiaries were treated at EDs, rather than UCCs

Policies addressing non-urgent care at hospital EDs

- Commercial insurers
 - Retrospective ED claims audits
 - Education campaigns
 - Nurse help lines and online applications available 24-hours a day to assist patients' decision-making about care settings
 - Quality measurement tools' tracking of ED non-urgent care
- State Medicaid programs
 - Cost-sharing imposed on beneficiaries for these ED visits (12 states)
 - Target super-utilizers for care management
 - Expand the availability of primary care services
 - Nurse help lines
 - Improve care coordination between EDs and physician offices

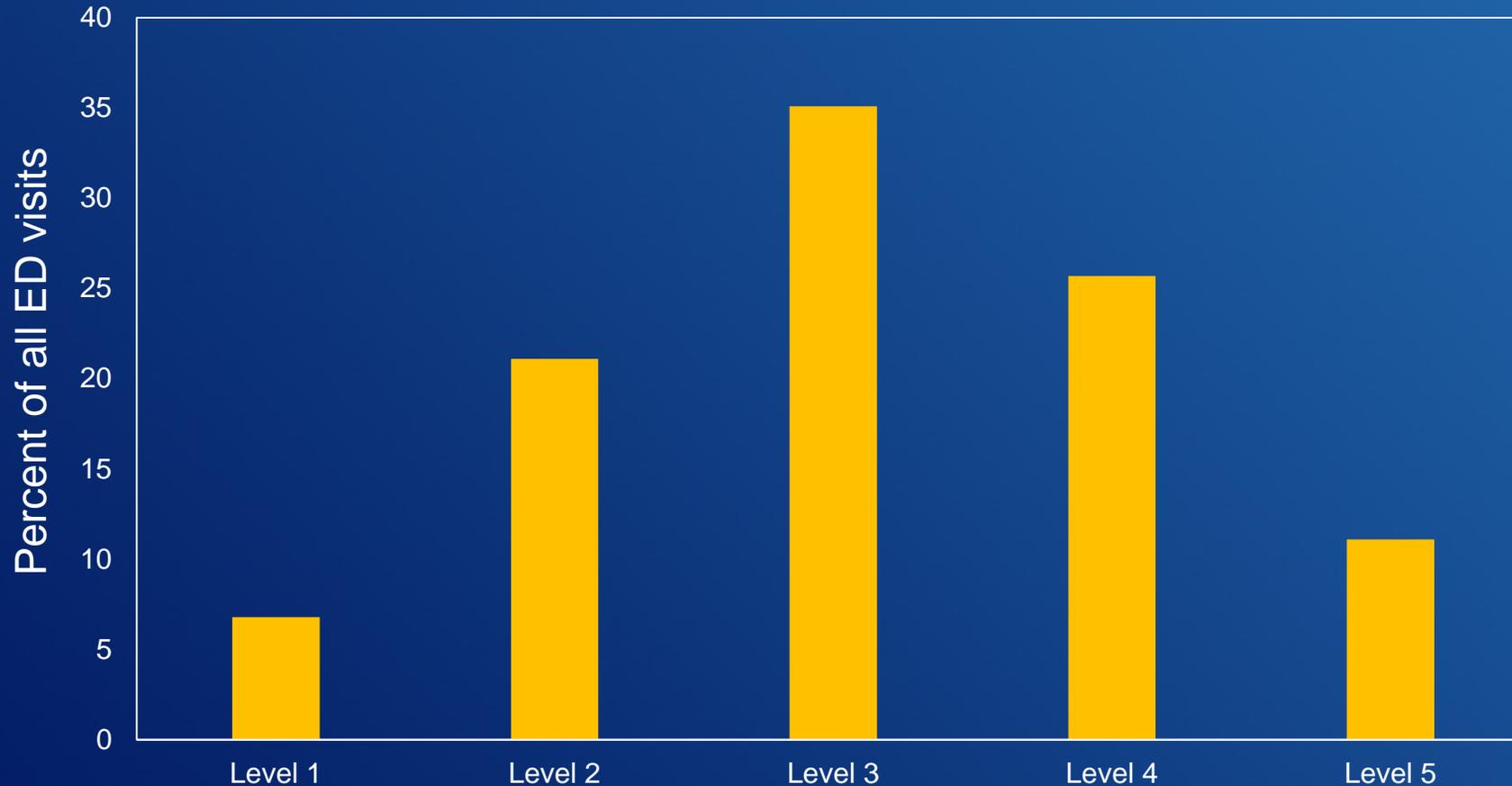
Policies to encourage more appropriate use of EDs

- Some policies may unnecessarily penalize patients for their decisions about where to seek care
- Policy options
 - Initiate a beneficiary education campaign to improve the understanding of appropriate ED and UCC use related to non-urgent care
 - Develop beneficiary educational materials, including a web site
 - Initiate a 24-hour nurse help line to assist beneficiary decision making
 - Expand quality measurement of avoidable ED use to provider types where the provision of non-urgent care is common
 - Improve care coordination between EDs and primary care physicians

Coding of ED visits

- ED codes: 5 levels, each reflects different level of resource use
- Payments increase with the level
- National guidelines for coding ED levels are not used; hospitals use internal guidelines

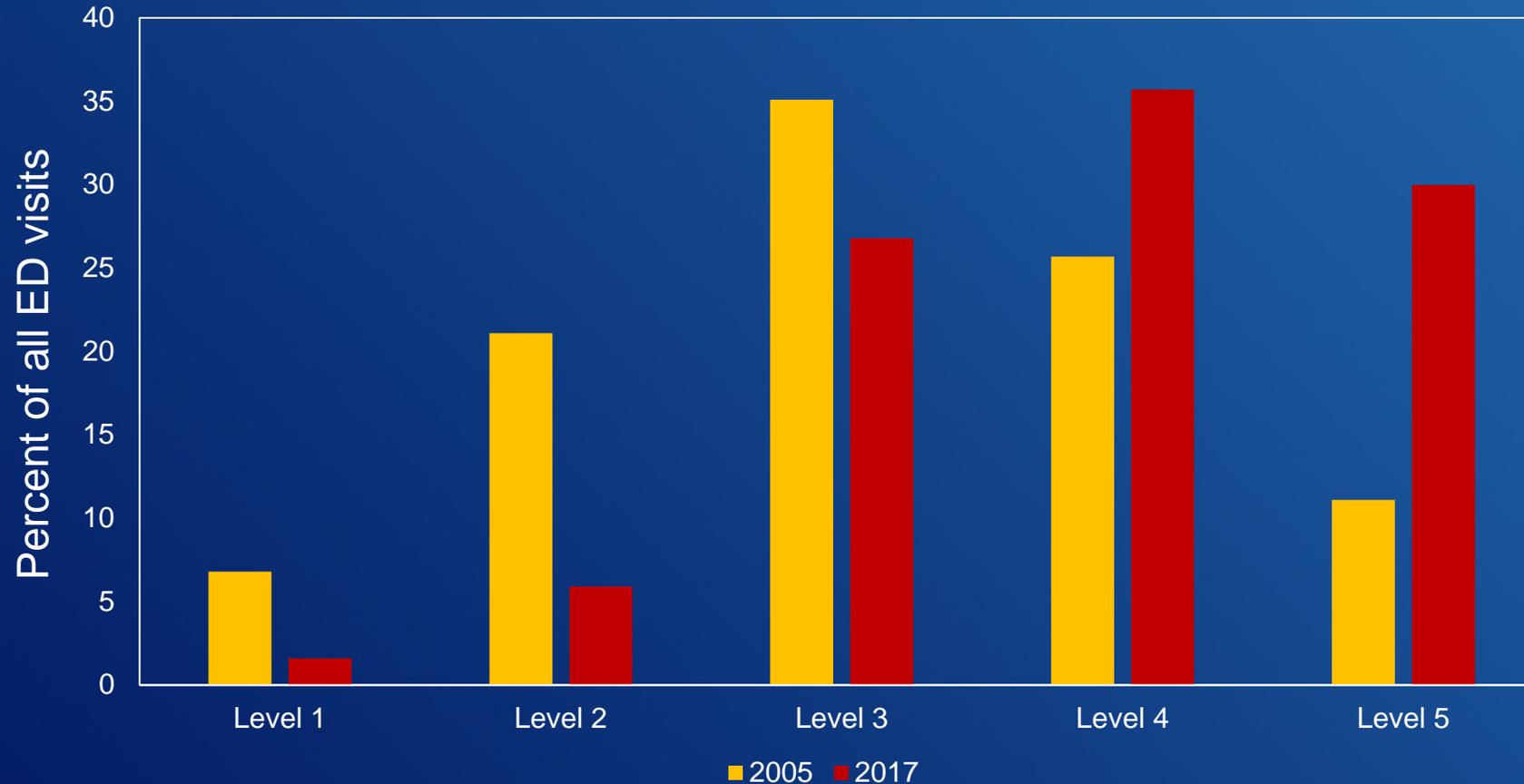
Coding of ED visits approximated normal distribution, 2005



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

Results are preliminary and subject to change

Coding of ED visits shifted to higher levels, 2005 to 2017



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Results are preliminary and subject to change

Why has coding shifted?

- Hospitals: Patients were sicker and medical advances produced better outcomes (potentially appropriate)
- Other experts: No change in patients; hospitals took advantage of coding rules (unwarranted)
- Academics: Hospitals provided more care; possible some upcoding occurred (mixed)

Are patients sicker?

- Same conditions treated 2011-2017
 - No change in principal diagnoses on claims
 - Little change in reasons patients gave for seeking care at EDs
- Across geographic areas, large differences in coding and in how coding changed
- No correlation between use of UCCs and coding of ED visits

More services during ED visits, despite no change in conditions treated

- Hospitals increased number of services provided during ED visits (NHAMCS, 2011-2016)
 - Increased use of screening services, especially CTs and EKGs
 - Little change in lab tests and procedures
- Claims analysis for 20 specific conditions (2011-2017)
 - EKGs common for chest pain; CT of head common for head injury
 - Fairly common: EKG and CT of head for UTI; use increased from 2011 to 2017

Addressing change in ED coding

- CMS: Normal distribution for ED visits desirable
- Coding of ED visits shifted to higher levels (2005-2017)
- No clear explanation for change in coding
- High concentration at level 5 with no change in patient conditions likely means Medicare payments are likely too high for many patients

National guidelines for coding ED visits

- In early years of OPPS, CMS (and others) tried unsuccessfully to develop national guidelines
- To improve coding of ED visits, CMS could revisit national guidelines
 - Payments would accurately reflect hospital resources used to provide ED care
 - Hospitals would have clear rules for coding ED visits
 - CMS would have firm foundation for assessing and auditing coding behavior

Discussion

- Information on urgent care centers
- Policy options
 - Non-urgent care in EDs
 - Establishing national guidelines for coding ED visits

