American Hospital Association

ISSUE BRIEF

Sicker, More Complex Patients are Driving up Intensity of ED Care

Summary

Policymakers have noted an upward shift in the intensity of services provided to fee-for-service (FFS) Medicare beneficiaries in hospital emergency departments (EDs), as reflected in the level of evaluation and management (E/M) visits coded. This report examines a number of factors contributing to this trend including:

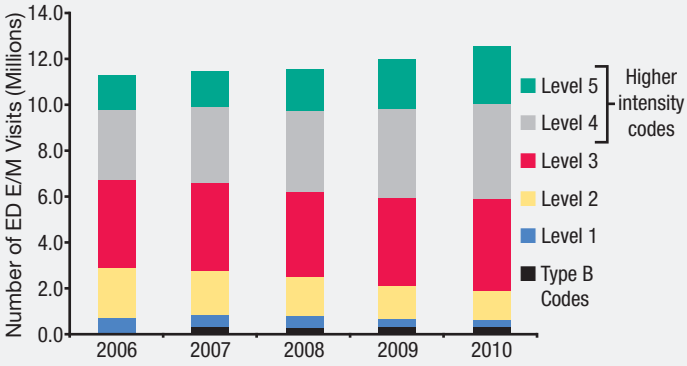
- Rising severity of illness among Medicare FFS patients receiving ED services;
- An increase in the number and frequency of ED visits by Medicare FFS beneficiaries;
- Increasing numbers of ED visits that include outpatient observation services due to mounting pressure to shift care from the inpatient to the outpatient setting;
- Greater use of the ED by people dually eligible for Medicare and Medicaid (dual-eligibles), who tend to be sicker and have more chronic conditions; and
- Increasing use of the ED by Medicare FFS beneficiaries with behavioral health diagnoses who require a higher intensity of services.

Background

Recent data indicate that the volume of evaluation and management (E/M) services provided to Medicare beneficiaries in the ED is growing, and that the mix of services is shifting toward services that demand higher resources (Chart 1). Policymakers have raised concerns that these trends are leading to higher spending on ED care for Medicare FFS beneficiaries. The ED visit codes at issue are Current Procedural Terminology (CPT®) 99281-99285, which correspond to Level 1 through 5 ED visits, and G0380-G0384, which are similar codes used in Type B EDs.[1] The codes indicating a higher level of service intensity are the ones at the upper end of each range. This report, based on an analysis of Medicare claims data conducted by The Moran Company,[2] outlines a number of factors that are contributing to this trend.

Medicare FFS beneficiaries are receiving a greater volume and intensity of ED services.

Chart 1: Number of Medicare FFS ED Visits by Evaluation and Management (E/M) Visit Code, 2006-2010



Source: The Moran Company, *Trends in the Provision of Emergency Department Evaluation and Management Services*, January 2013.

Coding of ED Visits

Hospitals have been using the CPT® E/M codes to report facility resources used to treat patients in the ED since April 2000. Facility resources include such things as time spent by nurses and other hospital staff in caring for patients and a variety of interventions performed by nursing or ancillary staff (e.g., administration of oral medication, wound cleaning, cardiac monitoring, catheter care, etc.) Recognizing that the E/M code descriptors, which were designed to reflect the activities of physicians, do not adequately describe the range and mix of services provided by hospitals, the Centers for Medicare & Medicaid Services (CMS) has instructed hospitals to develop internal hospital guidelines to determine the level of ED services provided. No national guidelines with clear and specific criteria have been adopted by CMS.

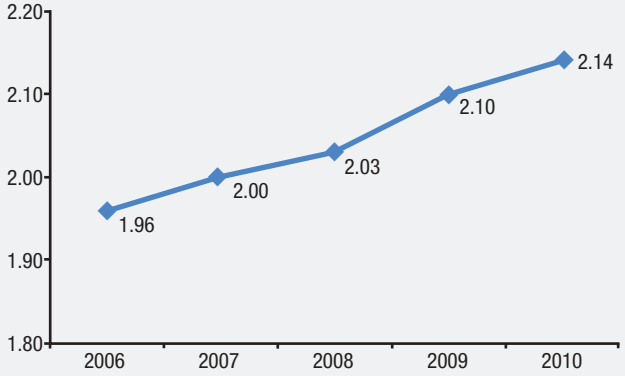
[1]Type B EDs are typically EDs that are open less than 24 hours a day, seven days a week.
See: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/OPPS_QandA.pdf
[2]The Moran Company (2013). *Trends in the Provision of Emergency Department Evaluation and Management Services.* Arlington, VA.

Medicare Beneficiaries Receiving ED Care are Getting Sicker

The increase in the use of more intensive ED E/M codes coincides with a marked increase in ED patient severity. From 2006 to 2010, the average severity of illness for Medicare FFS beneficiaries treated in the ED increased by 9 percent (Chart 2). This analysis is based on the Hierarchical Condition Category (HCC) scores of Medicare FFS beneficiaries visiting the ED. CMS developed HCC scores to measure expected resource utilization for risk adjustment in the Medicare Advantage Program. HCC scores are calculated based on all of the diagnoses reported for a beneficiary in a year across the inpatient, outpatient and physician office settings, as well as patient demographics. An HCC score represents a patient's expected future resource utilization and is used as a proxy for patient severity of illness. An increase in the average HCC scores of Medicare ED patients would be expected to drive an increase in the coded intensity of care provided.

Medicare ED patients are getting sicker…

Chart 2: Average HCC Scores for Medicare FFS Beneficiaries Visiting the ED, 2006-2010*

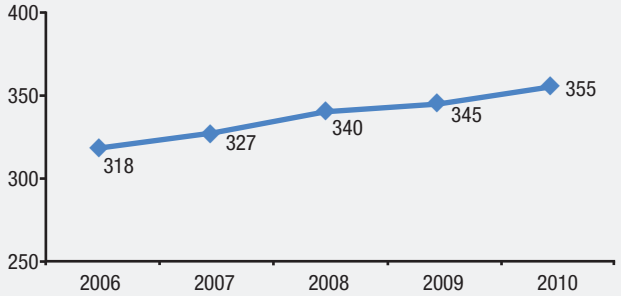


*These data are visit-weighted so that patient severity of illness is reflected for each visit.
Source: The Moran Company, *Trends in the Provision of Emergency Department Evaluation and Management Services*, January 2013.

The Rate of Use of ED Services by Medicare Beneficiaries is Rising

…and are using more ED services.

Chart 3: ED Visits per 1,000 Medicare FFS Beneficiaries, 2006-2010



Source: The Moran Company, *Trends in the Provision of Emergency Department Evaluation and Management Services*, January 2013.

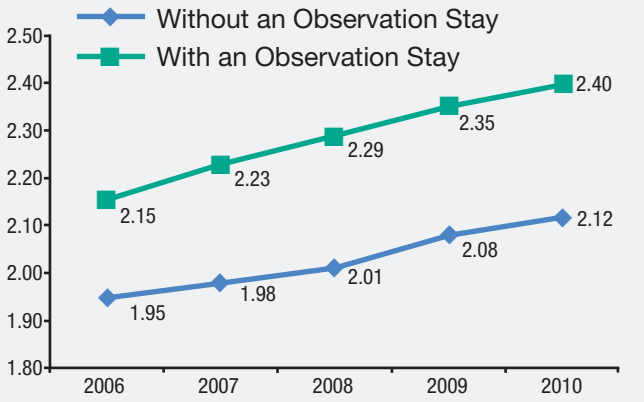
Another indicator of increased severity of illness among Medicare beneficiaries is the rising rate of ED use. Between 2006 and 2010, the average number of ED visits per 1,000 FFS beneficiaries rose by nearly 12 percent (Chart 3). During this same time period, 432,800 more Medicare beneficiaries used ED services, reflecting both growth in the Medicare FFS population and rising ED use, and the percent of beneficiaries with three or more visits in one year rose from 13.5 to 15.5 percent. These trends could also indicate lack of access to other types of medical care and/or the shift of care from inpatient to observation status (see next page).

Patients are Shifting from Inpatient to Observation Status

Patients with an observation stay are, on average, sicker than other ED patients (Chart 4). The number of ED visits that included outpatient observation services increased by 72 percent from 2006 to 2010, with about 1.1 million such visits in 2010. During that same time period, the share of patients with observation services grew 54 percent (Chart 5).[3]

Beneficiaries receiving observation care are sicker than other ED patients…

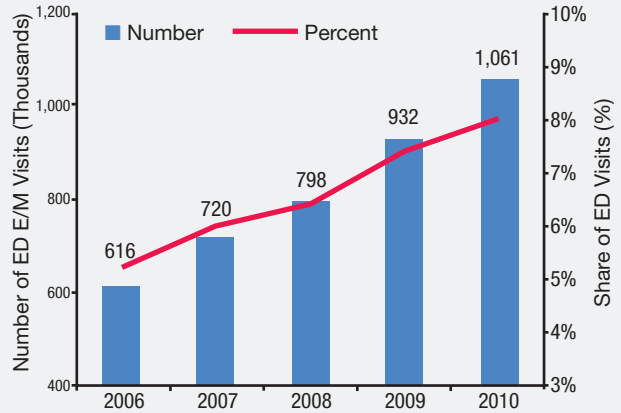
Chart 4: Average HCC Scores for Medicare FFS Beneficiaries Visiting the ED with and without an Observation Stay, 2006-2010*



*These data are visit-weighted so that patient severity of illness is reflected for each visit.
Source: The Moran Company, *Trends in the Provision of Emergency Department Evaluation and Management Services*, January 2013.

…and their numbers and share of ED visits are increasing.

Chart 5: Number and Share of Medicare FFS ED E/M Visits with an Associated Observation Stay, 2006-2010



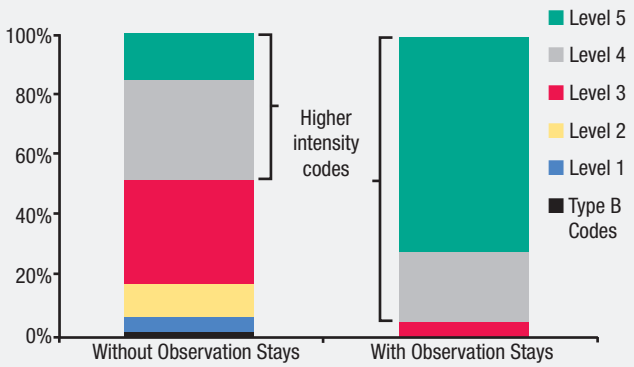
Source: The Moran Company, *Trends in the Provision of Emergency Department Evaluation and Management Services*, January 2013.

[3]Observation care is a well-defined set of specific, clinically appropriate [outpatient] services, which include ongoing short term treatment, assessment and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. *Medicare Benefit Policy Manual, CMS Pub. 100-02*, Chapter 6, §20.6

Heightened scrutiny of short-stay, inpatient admissions by Medicare auditors is a key driver of this trend.[4] More and more, auditors are retrospectively denying payment for short-stay, inpatient admissions, claiming that these patients could have been treated in the outpatient setting. In March, 2013, CMS modified previous Medicare policy that prevented hospitals from rebilling for Part B payment denied for this reason; the updated guidance permits hospitals to rebill and receive Part B outpatient payment for a partial set of services for these types of denials. However, after an interim period, CMS proposes to only allow hospitals to rebill claims within one year of the date of service, while auditors are permitted to review and deny claims that are up to three years old. These denials create a strong incentive to provide patients who would have previously been admitted for short stays with outpatient observation services instead. The overall shift in care from inpatient to observation status means that the claims of these patients are now being counted as part of the ED population. When a patient seen in the ED is admitted to an inpatient unit, the hospital only receives payment under the inpatient prospective payment system, and his or her ED visit is not included in the outpatient claims data analyzed by CMS and others. Given their greater complexity and longer length of stay, observation patients have a higher intensity of E/M services reflected in the higher code levels assigned (Chart 6). Thus, the shift from inpatient to observation status is contributing to the overall trend towards a higher coded intensity of care.

Observation patients receive a markedly higher coded intensity of care.

Chart 6: Distribution of ED Visits with and without Observation Stays by E/M Code, 2010



Source: The Moran Company, *Trends in the Provision of Emergency Department Evaluation and Management Services*, January 2013.

[4]AHA (2012). *Exploring the Impact of the RAC Program on Hospitals Nationwide: Results of AHA RACTrac Survey, 2nd Quarter 2012.* Washington, DC.

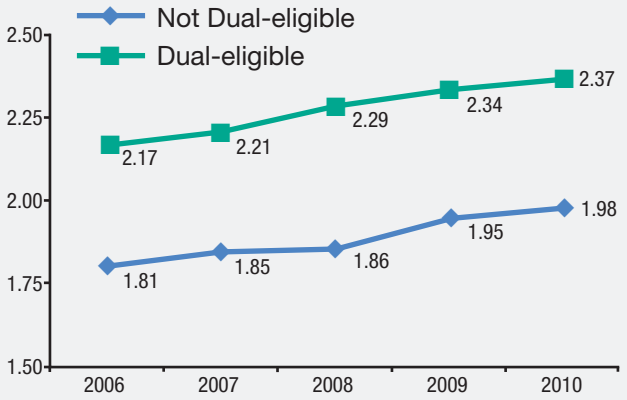
Use of the ED by Dual-Eligible Patients is Rising

Approximately 9.2 million Medicare beneficiaries are dually eligible for Medicaid. This population encompasses low-income seniors as well as younger people with disabilities. Dual-eligibles are among the sickest and poorest of Medicare beneficiaries. They are three times more likely to be disabled and have higher rates of diabetes, pulmonary disease, stroke, behavioral health disorders and Alzheimer's disease. This population makes up only 16 percent of Medicare beneficiaries but accounts for 27 percent of program costs.[5]

As would be expected, dually eligible ED patients have a higher severity level than other Medicare patients, and they too are getting sicker (Chart 7). The number of ED visits by beneficiaries who are dually eligible is increasing, and dual-eligibles now account for more than 40 percent of all Medicare FFS ED visits (Chart 8), another driver of the higher intensity of care provided in the ED over time.

Dual-eligible beneficiaries have a higher average level of severity and it is increasing.

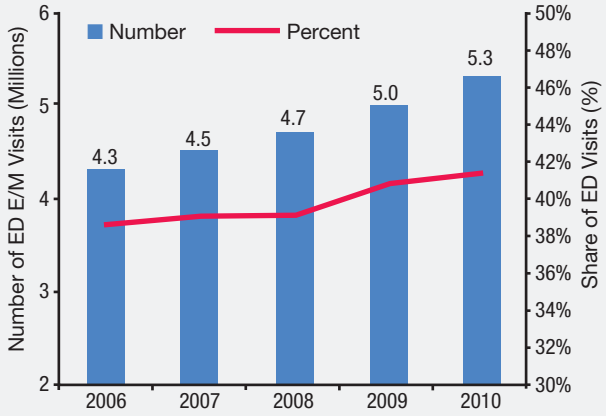
Chart 7: Average HCC Scores for FFS Beneficiaries Visiting the ED by Dual Eligibility Status, 2006-2010*



*These data are visit-weighted so that patient severity of illness is reflected for each visit.
Source: The Moran Company, *Trends in the Provision of Emergency Department Evaluation and Management Services*, January 2013.

The number and share of ED visits by dual-eligibles is rising.

Chart 8: Number and Share of Medicare FFS ED E/M Visits by Dual-eligibles, 2006-2010



Source: The Moran Company, *Trends in the Provision of Emergency Department Evaluation and Management Services*, January 2013.

EDs are Serving More Medicare Patients with Behavioral Health Diagnoses

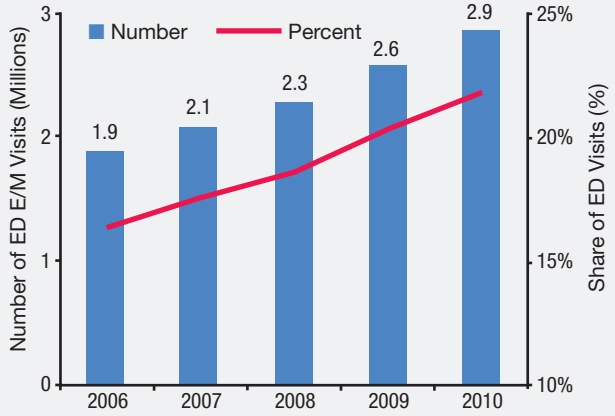
Patients with behavioral health diagnoses present many treatment challenges. These patients are less likely to comply with treatment recommendations and often have co-occurring medical conditions.[6] For patients needing inpatient or follow-up behavioral health care, both community and inpatient capacity has declined, resulting in an increased frequency of boarding in the ED until a more suitable treatment setting can be found.[7] A recent study found that psychiatric patients stay in the ED 3.2 times longer than non-psychiatric patients.[8] Additionally, these patients must be medically cleared before most specialized treatment facilities will accept them.

Between 2006 and 2010, the number of ED visits by Medicare FFS patients with a behavioral health diagnosis increased by close to 50 percent. These behavioral health-related ED visits rose from slightly more than 16 percent of all ED visits to about 22 percent over the same period (Chart 9). Given the treatment challenges and longer length of stay, these patients on average receive a higher level of care (Chart 10).

[5]Kaiser Family Foundation (January 2011). *The Role of Medicare for the People Dually Eligible for Medicare and Medicaid.* Washington, DC.
[6]Druss, B.G., and Walker, E.R. (February 2011). *Mental Disorders and Medical Comorbidity.* Research Synthesis Report No. 21. Princeton, NJ: The Robert Wood Johnson Foundation.
[7]Khazan, Olga (January 23, 2013). "Psychiatric Patients Wait in ERs for Days and Weeks as Inpatient Beds are Scaled Back." *The Washington Post*, p. B1.
[8]Nicks, B.A. and Manthey, D.M. (2012). "The Impact of Psychiatric Patient Boarding in Emergency Departments." *Emergency Medicine International*, Volume 2012, Article ID 360308.

ED visits for Medicare beneficiaries with a behavioral health diagnosis are increasing rapidly…

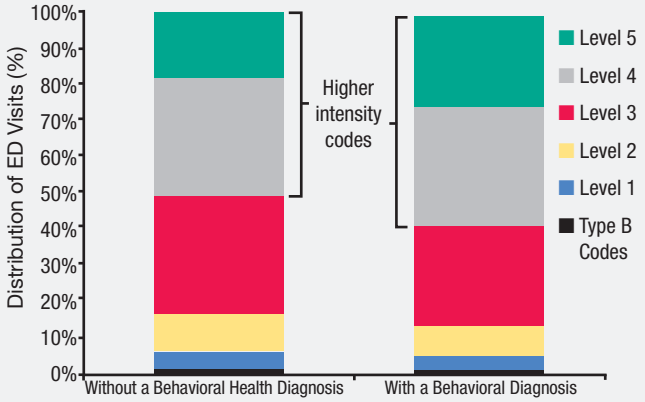
Chart 9: Number and Share of Medicare FFS ED E/M Visits for Patients with a Behavioral Health Diagnosis, 2006-2010



Source: The Moran Company, *Trends in the Provision of Emergency Department Evaluation and Management Services*, January 2013.

…and these patients, on average, have a higher coded intensity of care.

Chart 10: Distribution by E/M Codes for ED Visits with and without a Behavioral Health Diagnosis, 2010



Source: The Moran Company, *Trends in the Provision of Emergency Department Evaluation and Management Services*, January 2013.

Conclusion

The shift to a higher coded intensity of care among Medicare FFS ED patients reflects shifts in the patterns and characteristics of people seeking treatment. Between 2006 and 2010, the severity of illness of beneficiaries receiving E/M services in the ED increased, as did the rate of use. The number and share of ED visits with associated observation stays is increasing rapidly and these patients have a much higher coded intensity level of care. Beneficiaries dually eligible for Medicare and Medicaid – a population with a higher than average severity of illness – comprise a larger share of patients receiving E/M services in the ED over the study period. Likewise, patients with a behavioral health diagnosis show growth in use of ED E/M care over time and these visits have a higher mix of service intensity. These trends are all key drivers of the rising intensity of care provided to Medicare FFS ED patients and associated visit levels coded.

American Hospital Association®

325 Seventh Street, NW
Suite 700
Washington, DC 20004-2802
202.638.1100
www.aha.org