Using the ER as a Hospital Front Door and Revenue Generator

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One doctor's perspective……

- Current Member Board of Directors, American College of Emergency Physicians (ACEP)
- Immediate Past Chair , ACEP Reimbursement Committee
- Former President, Illinois College of Emergency Physicians
- Current Emergency Patient Interdisciplinary Care Team (EPIC)
- Disclosures – none other than above

Agenda/Objectives

- Identify current trends in ED utilization
  - Opportunities
  - Threats
- Identify emerging functions of ED services
  - Opportunities
  - Threats
- Strategies for value
  - Place ED services in emerging health care models

Misperceptions in Washington

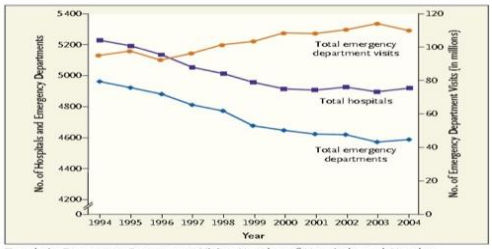
"I mean, people have access to health care in America, after all, you just go to an emergency room."

President George W. Bush, 2007

"The average family pays a thousand dollars in extra premiums to pay for people going to the emergency room who don't have health insurance."

President Barack Obama, June 2009

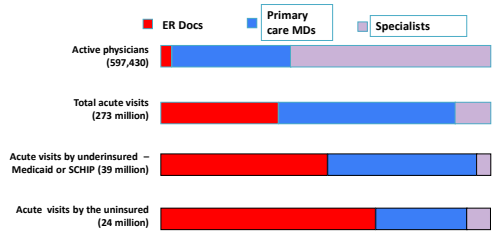
ED Volumes Trend Upward



Trends in Emergency Department Visits, Number of Hospitals, and Number of Emergency Departments in the United States, 1994–2004.

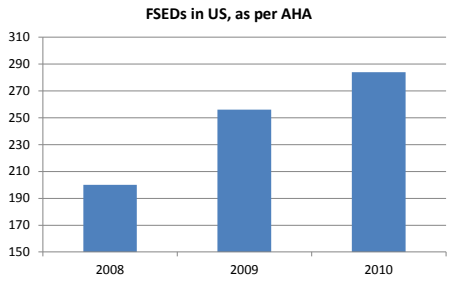
Visits to the emergency department represent about 10% of all outpatient visits in the United States. Data are from the National Health Policy Forum.

EDs Provide the Bulk of Acute Care to the Under- and Uninsured



Pitts et al. *Health Affairs*, Sept 2010

Tactic: Growth of Free Standing EDs

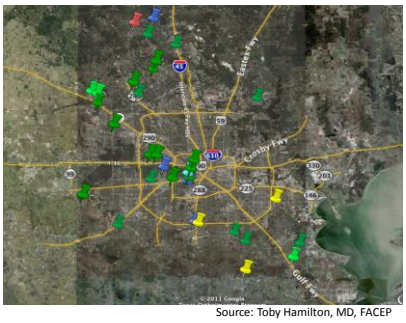


8700 Urgent Care Centers in US, growth slowing

2006: Houston FSEDs

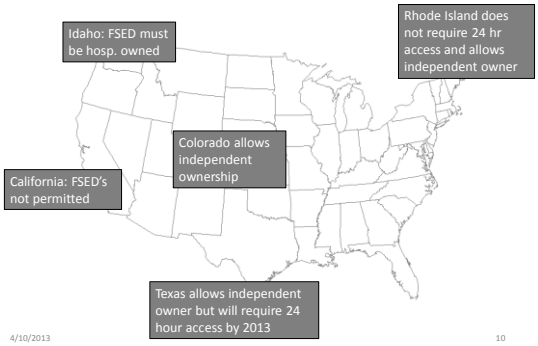
Source: Toby Hamilton, MD, FACEP

2011: Houston FSEDs



Source: Toby Hamilton, MD, FACEP

Regulation of FSEDs



ACA Causing Increased ED Volume?

Affordable Care Act:

- Insurance Mandate
- Expanded Medicaid eligibility (18 million new)
- Formulation of Insurance Exchanges
- Coverage for Dependents up to 26
- Guaranteed issue and renewability
- No pre-existing condition barriers
- Emergency Services categorized as "Essential Health"
- Exacerbated by Primary Care Shortage

71% of ED physicians polled think ED volumes up with ACA

The Massachusetts Experience

- Following global health coverage in Mass
  - 95% insured
  - ED self pay population changed: 15% to 7%
  - ED visits rose 9 percent
  - Insurance didn't equal access
- Robert Wood Johnson Foundation: Mass. ED visits continued to increase in 2008 even for non emergency care
  - 75.7% need for care after routine office hours
  - 55.8% inability to get an appointment

Medicare Rates for Medicaid

State	Current Pct. Of Medicare Rates
US Average	61%
CA	43%
GA	70%
FL	50%
IL	53%
NC	86%
ND	141% Highest
NY	51%
PA	56%
RI	33% Lowest

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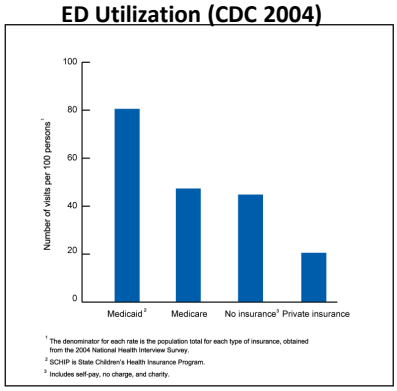
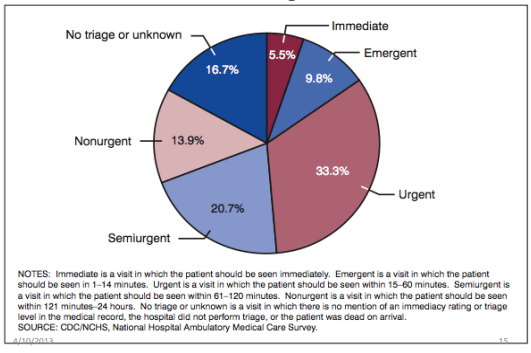
ED Utilization (CDC 2004)



[1] The denominator for each rate is the population total for each type of insurance, obtained from the 2004 National Health Interview Survey.
[2] SCHIP is State Children's Health Insurance Program.
[3] Includes self-pay, no charge, and charity.

Focus on Non-Urgent ED use

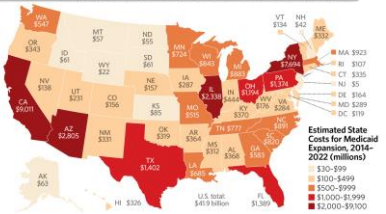


NOTES: Immediate is a visit in which the patient should be seen immediately. Emergent is a visit in which the patient should be seen in 1–14 minutes. Urgent is a visit in which the patient should be seen within 15–60 minutes. Semiurgent is a visit in which the patient should be seen within 61–120 minutes. Nonurgent is a visit in which the patient should be seen within 121 minutes–24 hours. No triage or unknown is a visit in which there is no mention of an immediacy rating or triage level in the medical record, the hospital did not perform triage, or the patient was dead on arrival.
SOURCE: CDC/NCHS, National Hospital Ambulatory Medical Care Survey.

Just 2% of each $

Potential Downside of Medicaid Expansion

State's Cost To Fund Medicaid Expansion



CBO Estimates After Federal Subsidy

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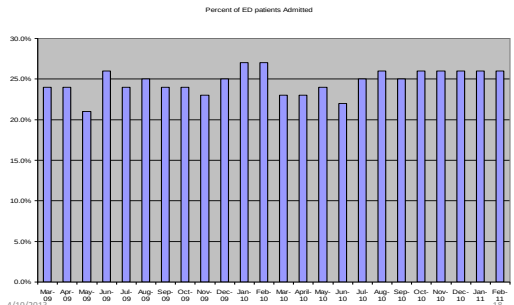
Percent of ED patients admitted



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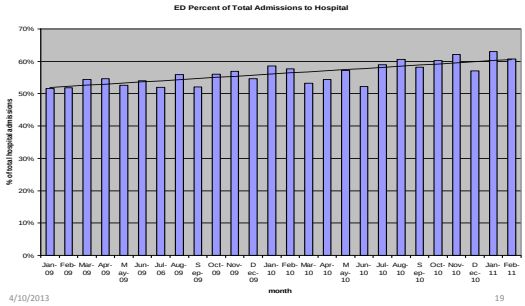
ED as Source of Admission



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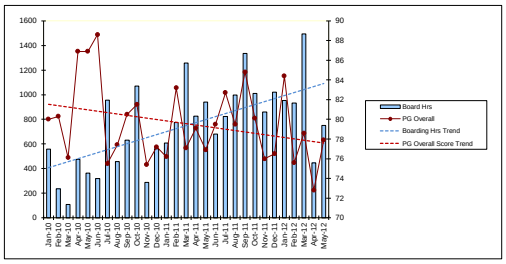
Boarding Hours and Patient Satisfaction



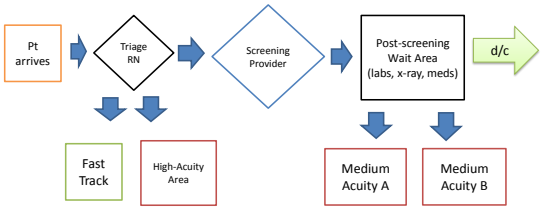
Solutions to crowding

- NQF measures (2012)
  - Median time from ED arrival to departure (admits)
  - Median time from ED arrival to departure (Dc's)
  - Median time from decision to admit to departure
  - Door to provider
  - LWBS

Tactics: Mid-Level Split Flow

Target ESI 3's

Patients directed by intake/triage nurse to provider [APN] for evaluation and tests/treatment are divided into higher acuity and lower acuity (or are discharged)



Tactic: Scribes
CMS definition of a Scribe

- *In Evaluation and Management E/M services, surgical, and other such encounters, the "scribe" does not act independently, but simply documents the physicians' dictation and/or activities for the visit."*

CMS CENTERS for MEDICARE & MEDICAID SERVICES

Decreasing "Left Without Being Seen" = Positive ROI

Cost Analysis of LWBS

- Net revenue (actual LWBS payor mix)
  - Outpatient facility net revenue @ **$300/visit discharge (90% of visits)**
  - Inpatient facility net revenue @ **$5,000/visit admission (10% of visits)**
  - Professional provider net revenue @ **$125/visit all (100% of visits)**
- 1% LWBS @ 50,000 visits = **500 visits**
- Lost opportunity net dollars for every 500 visits LWBS
  - **$135,000 facility outpatient revenue (450 pts x $300)**
  - **$250,000 facility inpatient revenue (50 pts x $5,000)**
  - **$62,500 professional revenue (500 pts x $125)**
- Cost of 1%LWBS at 50,000 volume = **$447,500**

PQRS Incentive Amount By Specialty 2010*

*represents 2.0% incentive for 2012 based on 2010 claims: latest year available

Specialty	Incentive Amount			Percent of National Total Incentives
	Mean	Median	Total	
Emergency Medicine	**$1,186.53**	**$ 970.65**	**$32,952,408**	**9.0%**
Cardiology	$6,582.86	$5,642.26	$44,750,285	12.3%
Family Medicine	$1,313.36	$ 887.99	$23,226,764	6.4%
General Surgery	$2,150.82	$1,641.43	$ 5,189,939	1.4%
Internal Medicine	$2,226.57	$1,537.27	$35,273,041	9.7%
All MDs/DOs	**2,519.87**	**1,364.14**	**$324,916,716**	**89.2%**

Physician Value-Based Payment Modifier (VBPM)

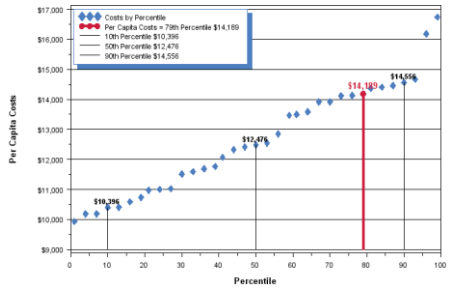
Statutory Timeline for VBM Implementation		
Reporting Period	**Value-Modified Payment Adjustment**	**Eligible Professionals Included**
2013	2015 payments	Groups ≥ 100
2014	2016 payments	To be determined
2015	2017 payments	**ALL ELIGIBLE PROFESSIONALS**

Return on Investment (ROI) for PQRS: What does it mean for our specialty?

Emergency Medicine	Mean	Median	Total
Actual 2% Incentive in 2012 for 2010 Reporting	$1,186.53	$ 970.65	$32,952,408
Projected +1.0% Total Potential PQRS Incentive 2013 Reporting	$ 593.26	$ 485.32	$16,476,204
Projected -2.5% Potential PQRS/VBPM Penalties 2013 Reporting	$1,483.15	$1,213.30	$41,190,510
Projected Total Potential Δ 2013 Reporting	**$2,076.41**	**$1,698.62**	**$57,666,714**

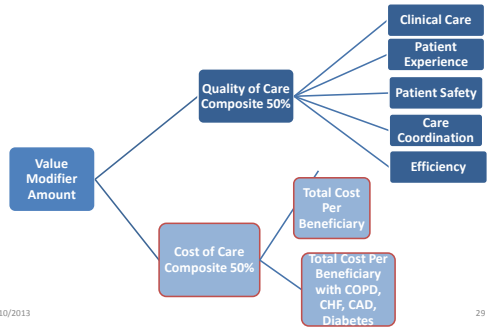
BOTTOM LINE: Emergency Physicians need measures in PQRS to receive full reimbursements!

QRUR Format Physician Cost Benchmarking: Per Capita Costs



Source: Toby Hamilton, MD, FACEP

National Quality Domains Used to Calculate the VBPM



Compliance Disputes

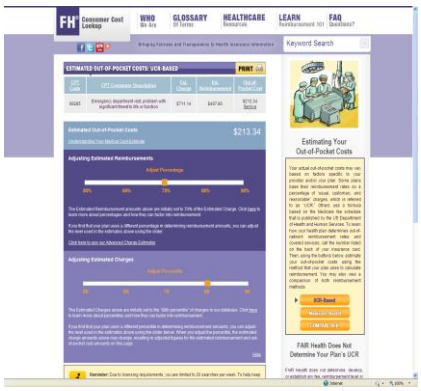
- Based on the HMO Settlement agreements
- ACEP is a signatory society representing all emergency physicians
- Issues include :
  - Bundling diagnostic testing and/or procedures into the visit code
  - Disparaging language on the EOBs

Current Ongoing Disputes

- Aetna
- Humana
- Anthem/ WellPoint
- National Blue Cross and Blue Shield in 7 states (FL, IL, MI, OK, OR, SC, TX)

Origins of FAIR Health

- From NY AG settlements with health plans
- Establish an independent not-for-profit organization tasked with creating a new database—FAIR Health.
- Establish a free consumer-friendly website that provides access to UCR benchmark data



http://www.fairhealthconsumer.org/medicalcostlookup/cost.aspx

CMS 438 highlights

CMS Manual System Pub 100-08 Medicare Program Integrity
Transmittal 438 Effective date December 10,2012

- Purpose: "To define progress notes and *Limited space progress note templates*"

"CMS does not prohibit the use of templates to facilitate record-keeping. " However….

8033.3 Review contractors shall remember that progress notes create with Limited Space Templates in the absence of other acceptable medic record entries do NOT constitute sufficient documentation of a face-to-f visit and medical examination. Cc: CERT, Medicare RACs, ZPICS

RAC Review and E/M Services

- Q: Will the Recovery Audit Contractors (RAC) review evaluation and management (E&M) services on physician claims under Part B?
- A: Yes, the review of all evaluation and management (E & M) services will be allowed under the RAC program. CMS will work closely with the physician community prior to any reviews being completed regarding the level of the visit.

RAC FAQ ID # 7738

Medicaid RACS

http://www.medicaid-rac.com/

Implemented Jan 1 2012:
- Involves all 50 states

Expected Recovery:
- 2013 $310m

Currently not Medicaid Managed Care

Issues under review:
- States have some flexibility
- Similar to CMS RACs
- Data mining
- Complex reviews

Some new players:
- HMS
- Optum Public Sector Solutions
- Myers & Stauffer LC
- Recovery Audit Specialists

The Future: ICD 10 Update 2014

Go Live Date 10.1.2014

- Physician Documentation Issues
  - Laterality: right, left, bilateral
  - Phase of care: Initial, Subsequent, Sequela
  - Anatomic specificity
- Chart construct
- Provider education

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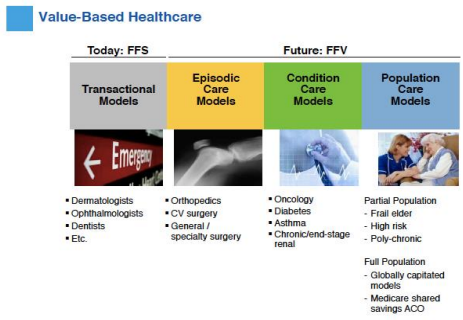
No Longer Revenue – But VALUE



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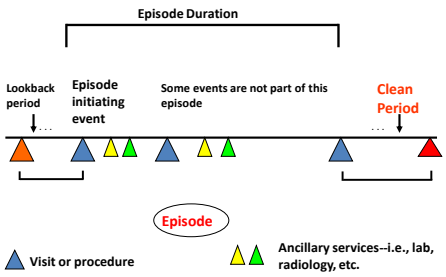
Bundled Payment Based on Episode Timeline



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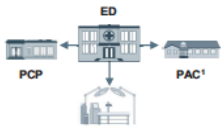
Our View: ED as Vital Component of System

ED as an Island

- ED is focused primarily on efficiency and myopically concerned with acute care episode only
- ED and hospital at large view ED care as separate from larger care continuum

ED as a Bridge



- ED is intrinsically connected to entire health care enterprise and focused on items beyond efficiency
- ED collaborates to help prevent readmissions, avoid preventable admissions and promote care coordination

Transforming the ED

Transforming the ED's Role in Delivering Agile and Coordinated Care

Assuming a Proactive Stance to Managing Capacity Constraints

Succeeding in the Future by Bridging Patients to Resources

1 *Fostering Collaborative Throughput*

1. Criteria-Based Midtrack Acuity Segmentation
2. Escalating Housewide-Capacity Protocol
3. Capacity-Dictated ICU Transfer Policy

2 *Strategizing Observation Patient Management*

4. Demand-Driven Observation Unit Sizing
5. Visibility-Enhanced Patient Cohorting
6. Abbreviated Patient Intake History
7. Front-Loaded Specialist Care Planning
8. Patient-Directed Observation Status Explanation

3 *Hardwiring Continuity of Care*

9. PCP-ED Automated Patient Handoff Note
10. SNF-ED Communication Transfer Tool
11. Dedicated Follow-Up Referral Specialist
12. Centralized ED Follow-Up Office
13. Geriatric-Focused Transition Planning

4 *Managing High Utilizer Populations*

14. Pain Management Accountability Escalation
15. Homeless Population Resource Link
16. Telepsych Consult Service
17. Personalized Post-Discharged Case Management
18. Contracted Outpatient Case Management

Observation Unit Added Value

Efficiency is Key to Observation Patient Management

Advantages of a Higher Turnover Rate

More Inpatient Capacity Generation

Stable, less complex patients treated as observation patients, freeing up more inpatient beds

Greater Capacity to Offload ED Volume

Patient shift to observation ensures greater inpatient bed availability, helping to offload ED

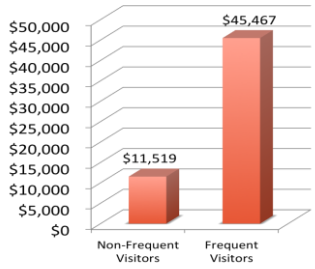
Lower Fixed Cost per Patient

Reduced length of stay improves efficiency of unit from cost perspective

Characteristics: Frequent Visitor Population

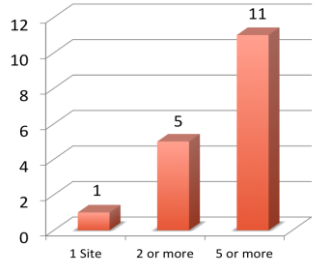
- Defined as 4 or more annual visits
- LaCalle and Rabin (2010)
  - ✓ More likely to be admitted to the hospital
  - ✓ More likely to have at least one chronic illness AND mental and substance abuse disorders
  - ✓ Have higher rates of morbidity and mortality
- Most frequent visitors have a primary care physician
- Use more of all health care resources
  - – Ambulatory, inpatient , social services, EMS

Illinois: Total Annual Medicaid Cost of Care



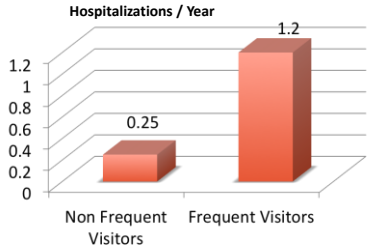
Source: CY2010 Medicaid Claims Data. All Illinois Health Connect patients having UI Health Systems Medical Home Frequent Visitors: n=1371, Non-Frequent Visitors: n=11,820

Illinois: Relative Patient Cost for multiple acute sites of care



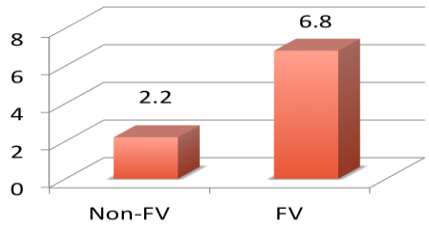
Source: Bourgeois, F. C., Olson, K. L., & Mandl, K. D. (2010). Patients treated at multiple acute health care facilities: Quantifying information fragmentation. *Archives of Internal Medicine, 170*(22), 1989-1995.

Illinois: Frequent ER Visitor Hospitalization Rates



Source: CY2010 Medicaid Claims Data. All Illinois Health Connect patients having UI Health Systems Medical Home
Frequent Visitors: n=1371
Non-Frequent Visitors: n=11,820

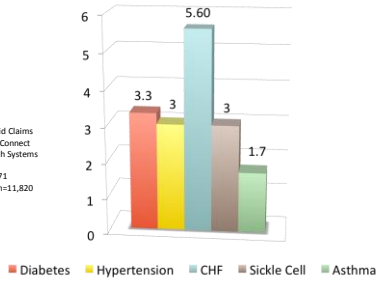
Illinois: Annual Ambulance Transports



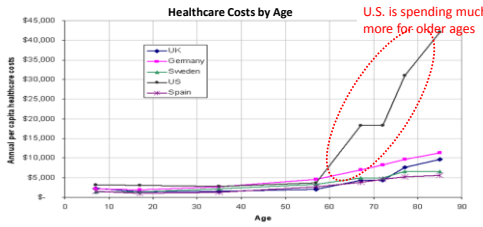
Source: CY2010 Medicaid Claims Data. All Illinois Health Connect patients having UI Health Systems Medical Home
Frequent Visitors: n=1371
Non-Frequent Visitors: n=11,820

Illinois: Frequent ER visitor hospitalization per year by chronic disease

Source: CY2010 Medicaid Claims Data. All Illinois Health Connect patients having UI Health Systems Medical Home
Frequent Visitors: n=1371
Non-Frequent Visitors: n=11,820

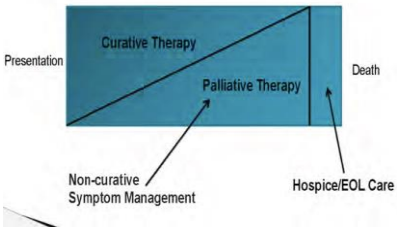


Healthcare Costs by Age



Palliative Care Continuum

Can This Continuum Work in the ED?



Palliative Care in the Conversation

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