WHAT IMPLICATIONS DOES THE AFFORDABLE CARE ACT HAVE FOR EMERGENCY MEDICINE?
OBJECTIVES

- Overview of ACA
- ACA and ED utilization
- ACA and reimbursements
OVERVIEW OF ACA-EXPANDING COVERAGE

- Individual Mandate:
  - Sign up or pay fine (3/31)
  - Some exemptions

- Employer Mandate:
  - > 50 employees → must provide insurance or pay penalty (2015-2016)

- Medicaid Expansion
  - 133% of Federal Poverty Level
  - 19 states did not expand

- Increased funding for CHIP enrollment

- Coverage of dependents until 26 yo

- Funding for Medicare Part D “donut hole”
  - Rebate $250
  - Complete elimination by 2020
Individual and small business exchanges

- American Health Benefits Exchange-state based
- Small Business Health Options Program (2017)

- 4 benefit categories: Bronze (60%), Silver (70%), Gold (80%), Platinum (90%); Catastrophic plan (30 yr or younger)

- 17 state-based marketplace, 7 partnership marketplaces, 27 federal run
Estimate of Exchange Enrollment by 2014

[Map of the United States with states color-coded by enrollment percentage:]
- States in blue: \( \geq 80\% \)
- States in dark blue: 60-79%
- States in orange: 40-59%
- States in green: \( \leq 39\% \)
OVERVIEW OF ACA: INCREASING PCP ACCESS

- Funding for PCPs in shortage areas
- Increased payments to rural health providers
- Increased payments to PCPs taking Medicaid
Exhibit 5. Timeline for Implementation of Primary Care Provisions in the Affordable Care Act

2010
- Student loan support to strengthen the health care workforce:
  - primary care student loans
  - nursing student loans
  - pediatric health care workforce student loans
  - Additional funding for Community Health Centers and the National Health Service Corps begins

2011
- Increased Medicare reimbursement (10%) for primary care services
- State option to allow Medicaid beneficiaries with chronic conditions to designate a health home
- Grants to develop community-based collaborative care networks

2012
- Medicare demonstration program to test payment incentives and delivery system models that utilize home-based primary care teams

2013
- Medicaid primary care provider payment rates set no lower than Medicare rates
- Preventive service coverage for adult Medicaid beneficiaries without cost-sharing increases federal Medicaid assistance percentages
- Grants for states to establish primary care extension centers

2014–2017
- Qualified health plans offering in the exchanges must include federally qualified health centers in covered networks and reimburse at minimum of Medicaid rates
- HHS grants or contracts to establish community health teams to support patient-centered medical homes
## OVERVIEW OF ACA: IMPROVING QUALITY

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Common Name</th>
<th>Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient-Centered Outcomes Research Institute</td>
<td>PCORI</td>
<td></td>
</tr>
<tr>
<td>Bundled Payment for Care Improvement Initiative</td>
<td>BPI</td>
<td>2013</td>
</tr>
<tr>
<td>Accountable Care Organizations</td>
<td>ACOs</td>
<td></td>
</tr>
<tr>
<td>Hospital Readmission Reduction Program</td>
<td>HRRP</td>
<td>2012</td>
</tr>
</tbody>
</table>
OVERVIEW OF ACA: COST CONTAINMENT

- Medicare payment reform
  - shared cost savings/shared losses
  - Value-based purchasing program
    - Payments linked to quality outcomes
    - Bonus payments
- Independent Payment Advisory Board (IPAB)
- Reduce special funding for safety net hospitals
- Increased anti-fraud activities
Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE

Thursday, December 5, 2013

20 Detroit-area Residents Charged in Medicare Fraud Strike Force Takedown for Approximately $34 Million in False Billing
Removal of pre-existing condition exclusions

No lifetime limits on coverage

No higher co-payments for out-of-network emergency care; providers also reimbursed
WHAT DOES THE ACA SAY ABOUT EM?

- All benefits packages must include emergency services
- Prudent layperson: reimbursement for emergency care based on a patient’s symptoms
  - One who possesses an average knowledge of health and medicine
- Emergency/Trauma Regionalization
- Supports more EM research
HOW WILL THE ACA AFFECT ED UTILIZATION?
WHAT HAPPENS TO ED USE AFTER UNIVERSAL COVERAGE?

Annals of Emergency Medicine


Emergency Department Utilization After the Implementation of Massachusetts Health Reform

Peter Smulowitz, MD
Instructor in Medicine
Emergency Medicine
BIDMC-Harvard

Bruce Landon, MD MBA
Associate Professor
Healthcare Policy
Univ. of Alabama
Emergency Department Utilization After the Implementation of Massachusetts Health Reform

- Massachusetts implemented healthcare reform in 2006
- Reduced uninsured to 2.4% (2009) from 10% prior to reform
  - expansion of MassHealth (Medicaid)
  - Enrollment in Commonwealth Care (low income)
  - Commonwealth Connector (insurance exchange)
- Documented reduced financial barriers to accessing care
Emergency Department Utilization After the Implementation of Massachusetts Health Reform

- Massachusetts has most primary care physician per capita in US
- 2007, 1 in 5 reported difficulty obtaining care
  - Most severe in specific areas of PCP shortages
- Utilization of ED based upon several factors:
  - Access
  - Convenience
  - Severity (or perceived severity) of health problems
- Nonetheless, hypothesis is increased access would decrease ED utilization
METHODS

• Billing data from 1/2006 to 9/2008
  • 11 hospitals: 4 tertiary academic center, 2 community, 3 safety-net/community, 2 safety-net/academic centers
  • 587,000 visits
• ED hospital utilization examined year before compared to 2 years after
• Focus on rates of low and high severity ED visits and rates of ambulatory care sensitive hospitalizations from the ED visits
• Pre-post difference in differences amongst publicly subsidized and those not affected by health reform
• 3 pops of ptx: uninsured (self-pay), enrollees in MassHealth, and uncompensated care pool, this group compared to commercially insured group
RESULTS

- Overall ED visits increased by 4.1% from 2006-2008
- Low severity visits
  - study group decreased 43.8% to 41.2% (diff 2.6%)
  - comparison group decreased 35.7% to 34.9% (diff 0.8%)
  - Diff in diff 1.8% p<0.001
- High severity visits
  - Study group decreased 9.8% to 9.4% (p<0.05)
  - Comparison group decreased 12.2% to 11.6% (p<0.05)
  - Diff in diff 0.2% (p<0.05%)

Table 2. Overall ED visits and visit severity for the uninsured/publicly subsidized group and the comparison group.

<table>
<thead>
<tr>
<th></th>
<th>Publicly Subsidized/Uninsured Group, Period</th>
<th>Comparison Group, Period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Total visits</td>
<td>157,586</td>
<td>159,212</td>
</tr>
<tr>
<td>Severity category, %</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>43.8</td>
<td>42.8</td>
</tr>
<tr>
<td>Indeterminate</td>
<td>29.9</td>
<td>29.4</td>
</tr>
<tr>
<td>High</td>
<td>9.8</td>
<td>9.5</td>
</tr>
<tr>
<td>Unclassified</td>
<td>16.4</td>
<td>18.3</td>
</tr>
<tr>
<td>Change From Period 1 to Period 3 (95% CI)</td>
<td>-2.6 (2.25 to 2.85)</td>
<td>-0.4 (-0.17 to -0.63)</td>
</tr>
<tr>
<td>Difference in Difference Between Study Group and Comparison Group (95% CI)</td>
<td>-1.8 (-1.7 to -1.9)</td>
<td>0.1 (0.09 to 0.11)</td>
</tr>
</tbody>
</table>

Confidence interval.
CONCLUSIONS

• Increase in overall ED utilization despite decrease in number of uninsured
• Decrease in low-severity ED visits, more notable with study group
• Although access to health care may be improved, it may be dependent upon availability of primary care
• Other factors play a role in ED utilization in addition to insurance status i.e. PCP availability, ED hours, patients’ perception of severity of illness
• Limitations:
  • Only 1 year before and after reform
  • Visit level information, not patient level
  • Convenience sample of hospitals (does not include small hospitals)
  • Decrease in low severity visits may be secondary to increase in unclassified group
2008, Oregon had limited expansion of Medicaid program
  
  • 30,000 names by lottery from waiting list of 90,000 selected
  
Study effects of Medicaid coverage for uninsured on ED use with randomized
  
Allowed for isolation of causal effect of insurance on ED visits and care
  
Minimized confounding variables
METHODS

• Inclusion criteria:
  • 19-64 yo
  • Oregon residents; US citizens or legal immigrants w/o health insurance for 6 months
  • Income below FPL
• ED analysis restricted to 5 digit postal code
• Visit-level data for all ED visits to 12 hospitals in Portland from 2007-2009
• Study period: 3/2008-9/2009
• Follow-up with people on the lottery list
  • Survey 1 year after
  • In-person interviews 2 years after
RESULTS

• Medicaid increased ED use
  • Increase in visits solely in outpatient visits
  • Both on and off hours use increased
DISCUSSION

• Economically, reducing out-of-pocket cost of a visit faced by uninsured by giving Medicaid should increase use of the ED
• Medicaid increases ED use with estimated an average increase of 0.41 visits per covered person over an 18 month period
• If average cost of ED visit is $435, Medicaid increases annual spending in the ED by about $120 per covered individual
• Medicaid increased self-reported primary care use and perception of getting higher quality of care
• Limitations:
  • Population primarily white and urban dwelling
  • Voluntarily signed up for coverage
HIGH DEDUCTIBLE PLANS AND ED CARE
Low-Socioeconomic-Status Enrollees In High-Deductible Plans Reduced High-Severity Emergency Care

Low-Socioeconomic-Status Enrollees In High-Deductible Plans Reduced High-Severity Emergency Care

- High deductible plans are expected to accelerated enrollment
- Meant to discourage ED visits for low severity conditions
- Previous research shows patients continue to make high-severity ED visits
- High deductible have been shown to reduce hospitalizations
- How do high deductible plans affect people of low socioeconomic status?
METHODS

• 2002 Harvard Pilgrim Health Care began offering high deductible health plans with deductibles $500-$2000
• Groups:
  • High deductible (16,342): 1 year of continuous HMO enrollment followed by at least 6 months of high-deductible plan between 4/2001-2/2008
  • HMO (49,026): at least 18 months of mandated traditional HMO plan enrollment
• ED visits categorized as high severity (75% probability requiring ED care), all others low severity
• Low socioeconomic index=highest poverty and lowest education
• Compared utilization during baseline 4 quarters compared with follow-up 8 quarters
• Initial baseline ED visit trends had no detectable difference.
• 1st f/u year, study group members with low SES had significant decreases in high severity ED visits 95% CI (-2.23 to -0.28).
• 2nd f/u year, study group members with low SES had more baseline or similar high severity ED visits 95% CI (0.02, 0.28).

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Low socioeconomic status</th>
<th>High socioeconomic status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Study group</strong> (n = 5,854)</td>
<td><strong>Control group</strong> (n = 16,064)</td>
<td><strong>Study group</strong> (n = 10,488)</td>
</tr>
<tr>
<td>1-4</td>
<td>4.2%</td>
<td>4.7%</td>
</tr>
<tr>
<td>5-18</td>
<td>17.2%</td>
<td>17.3%</td>
</tr>
<tr>
<td>18-64</td>
<td>78.6%</td>
<td>78.0%</td>
</tr>
<tr>
<td>Percent female</td>
<td>51.0%</td>
<td>50.2%</td>
</tr>
<tr>
<td>Percent in family plan</td>
<td>63.3%</td>
<td>64.1%</td>
</tr>
<tr>
<td>Percent in small firm</td>
<td>62.5%</td>
<td>72.0%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>3.0%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Asthma</td>
<td>2.2%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>7.0%</td>
<td>6.1%</td>
</tr>
<tr>
<td>Adjusted Clinical Groups Score, mean</td>
<td>0.95</td>
<td>1.01</td>
</tr>
<tr>
<td>Percent in neighborhood below federal poverty level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 5%</td>
<td>23.2%</td>
<td>23.9%</td>
</tr>
<tr>
<td>5-9.9%</td>
<td>32.3%</td>
<td>34.0%</td>
</tr>
<tr>
<td>10-19.9%</td>
<td>32.0%</td>
<td>29.1%</td>
</tr>
<tr>
<td>20% or more</td>
<td>12.5%</td>
<td>12.9%</td>
</tr>
<tr>
<td>Percent living in neighborhoods with less than high school education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 15%</td>
<td>34.2%</td>
<td>35.0%</td>
</tr>
<tr>
<td>15-24.9%</td>
<td>42.8%</td>
<td>41.9%</td>
</tr>
<tr>
<td>25-39.9%</td>
<td>16.7%</td>
<td>17.9%</td>
</tr>
<tr>
<td>40% or more</td>
<td>6.3%</td>
<td>5.3%</td>
</tr>
<tr>
<td><strong>ED copay</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$25-$50</td>
<td>5.4%</td>
<td>11.2%</td>
</tr>
<tr>
<td>$50</td>
<td>75.0%</td>
<td>76.0%</td>
</tr>
<tr>
<td>$75-$100</td>
<td>18.6%</td>
<td>12.8%</td>
</tr>
<tr>
<td><strong>Mean inpatient copay</strong></td>
<td>$286.6</td>
<td>$270.1</td>
</tr>
<tr>
<td><strong>Mean annual expenses</strong></td>
<td>$1,604.7</td>
<td>$1,954.5</td>
</tr>
</tbody>
</table>

**Source:** Authors' calculations using Harvard Pilgrim Health Plan data. **Notes:** High and low socioeconomic status are defined in the text. Small firms are those with fifty or fewer employees. High-deductible health plan members are the study group, and health maintenance organization members are the control group.
Although study’s conclusion, shows decreased high acuity ED visits amongst members with high deductible plans, clinically not as significant

Amongst people with high SES, significant decrease in Low severity ED visits

Policy Implications: reconsider high deductible plans and perceived savings

Limitations:
- generalizable only to small employers
- Did not include any high deductible plans with health savings accounts
HOW WILL THE ACA AFFECT ED REIMBURSEMENTS?
WHAT HAPPENS TO ED USE AFTER UNIVERSEAL COVERAGE?

Annals of Emergency Medicine


Anticipated Changes in Reimbursement for US Outpatient Emergency Department Encounters After Health Reform

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George Washington University Hospital
Anticipated Changes in Reimbursement for US Outpatient Emergency Department Encounters After Health Reform

• Estimated 30 million individuals will remain uninsured after ACA implementation
• ED utilization will either stay stable or increase after complete implementation of ACA
• This study assessed how reimbursements will be affected as newly eligible patients gain coverage
METHODS

• Medical Expenditure Panel Survey from 1/2005 to 12/2010
• Primary variable: insurance status, two levels
  • 0: Medicaid 1: Uninsured newly eligible; used to model Medicaid expansion
  • 0: Private 1: Uninsured ineligible; used to model insurance expansion through exchanges
• Outcomes: payments, charges and reimbursement ratios
• Two comparisons:
  • Uninsured newly Medicaid eligible group and the Medicaid group
  • The uninsured Medicaid ineligible group and the privately insured
• ED visits → admission were excluded (n=985)
• Visits paid by flat fee excluded (n=452)
• 18,328 encounters
• Most characteristics except metropolitan statistical area and age, had significant proportional differences

Table 1. Descriptive characteristics of outpatient ED visits by insurance category: Medical Expenditure Panel Survey, 2005 to 2010.†

<table>
<thead>
<tr>
<th>Demographic Factors</th>
<th>All (n=18,328)</th>
<th>Medicaid (n=5,847)</th>
<th>Newly Eligible (n=2,493)</th>
<th>Inseligible (n=1,324)</th>
<th>Private (n=8,664)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, mean (SD), y&lt;sup&gt;1&lt;/sup&gt;</td>
<td>38.9 (13.2)</td>
<td>36.7 (13.2)</td>
<td>36.7 (13.1)</td>
<td>38.7 (11.8)</td>
<td>41.1 (13.1)</td>
</tr>
<tr>
<td>Sex (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>632</td>
<td>75.1</td>
<td>61.5</td>
<td>48.0</td>
<td>58.0</td>
</tr>
<tr>
<td>Male</td>
<td>366</td>
<td>24.9</td>
<td>38.5</td>
<td>22.0</td>
<td>42.0</td>
</tr>
<tr>
<td>Race/ethnicity (%)&lt;sup&gt;2&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White, non-Hispanic</td>
<td>48.6</td>
<td>39.6</td>
<td>42.2</td>
<td>46.4</td>
<td>56.9</td>
</tr>
<tr>
<td>Black</td>
<td>24.2</td>
<td>29.7</td>
<td>24.1</td>
<td>19.6</td>
<td>21.2</td>
</tr>
<tr>
<td>Hispanic</td>
<td>22.0</td>
<td>25.0</td>
<td>30.0</td>
<td>20.9</td>
<td>15.9</td>
</tr>
<tr>
<td>Asian</td>
<td>2.1</td>
<td>0.9</td>
<td>0.8</td>
<td>1.1</td>
<td>3.4</td>
</tr>
<tr>
<td>Other</td>
<td>3.1</td>
<td>0.9</td>
<td>2.9</td>
<td>4.0</td>
<td>2.6</td>
</tr>
<tr>
<td>Education level (%)&lt;sup&gt;3&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>29.7</td>
<td>44.2</td>
<td>44.8</td>
<td>31.4</td>
<td>15.3</td>
</tr>
<tr>
<td>High school graduate</td>
<td>345</td>
<td>34.1</td>
<td>38.3</td>
<td>38.7</td>
<td>33.0</td>
</tr>
<tr>
<td>Some college</td>
<td>22.2</td>
<td>17.4</td>
<td>14.1</td>
<td>20.9</td>
<td>28.0</td>
</tr>
<tr>
<td>College (4 y or more)</td>
<td>13.7</td>
<td>4.4</td>
<td>2.9</td>
<td>0.0</td>
<td>23.7</td>
</tr>
<tr>
<td>Marital status (%)&lt;sup&gt;4&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>426</td>
<td>25.5</td>
<td>37.4</td>
<td>37.8</td>
<td>56.5</td>
</tr>
<tr>
<td>Widowed/divorced/separated</td>
<td>234</td>
<td>30.2</td>
<td>21.7</td>
<td>26.9</td>
<td>38.5</td>
</tr>
<tr>
<td>Never married</td>
<td>33.9</td>
<td>44.3</td>
<td>40.9</td>
<td>33.2</td>
<td>25.1</td>
</tr>
<tr>
<td>Region (%)&lt;sup&gt;5&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northeast</td>
<td>15.3</td>
<td>17.7</td>
<td>9.4</td>
<td>11.9</td>
<td>15.8</td>
</tr>
<tr>
<td>Midwest</td>
<td>23.3</td>
<td>23.9</td>
<td>17.6</td>
<td>16.7</td>
<td>26.4</td>
</tr>
<tr>
<td>South</td>
<td>40.2</td>
<td>34.6</td>
<td>55.9</td>
<td>46.8</td>
<td>38.5</td>
</tr>
<tr>
<td>West</td>
<td>21.2</td>
<td>23.8</td>
<td>17.0</td>
<td>24.7</td>
<td>20.2</td>
</tr>
</tbody>
</table>

METROPOLITAN STATISTICAL AREA (%)<sup>6</sup>

| Yes | 823 | 81.1 | 79.2 | 79.6 | 64.3 |
| No  | 177 | 18.9 | 20.8 | 20.4 | 15.7 |

‡P<0.05 for comparisons of Medicaid-inseligible group with all other groups; remaining comparisons are not statistically significant.

‡P<0.05 across all groups.

‡P<0.05 for comparisons of private group with all other groups; remaining comparisons are not statistically significant.
RESULTS

- Adjusted payments for uninsured Medicaid newly eligible vs. Medicaid group were $34 lower
- Adjusted charged were $171 lower
- Reimbursement ratios showed Medicaid visits reimbursed an additional 17% of charges

Table 2. Total payments, total charges, and reimbursement ratios for outpatient ED visits by insurance category: Medical Expenditure Panel Survey.*

<table>
<thead>
<tr>
<th>Period (y)</th>
<th>Uninsured Newly Eligible</th>
<th>Medicaid</th>
<th>Medicaid vs Uninsured Newly Eligible</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Means</td>
<td>95% CI</td>
<td>Means</td>
</tr>
<tr>
<td>2005-2006</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total payments</td>
<td>477</td>
<td>451 to 496</td>
<td>570</td>
</tr>
<tr>
<td>Total charges</td>
<td>1,815</td>
<td>1,766 to 1,864</td>
<td>1,899</td>
</tr>
<tr>
<td>Reimbursement ratio</td>
<td>33.9</td>
<td>33.2 to 34.6</td>
<td>40.2</td>
</tr>
<tr>
<td>2007-2008</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total payments</td>
<td>425</td>
<td>424 to 425</td>
<td>609</td>
</tr>
<tr>
<td>Total charges</td>
<td>2,034</td>
<td>2,019 to 2,050</td>
<td>2,346</td>
</tr>
<tr>
<td>Reimbursement ratio</td>
<td>26.5</td>
<td>26.4 to 26.7</td>
<td>31.5</td>
</tr>
<tr>
<td>2009-2010</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total payments</td>
<td>679</td>
<td>101 to 1,256</td>
<td>504</td>
</tr>
<tr>
<td>Total charges</td>
<td>1,811</td>
<td>518 to 3,105</td>
<td>1,966</td>
</tr>
<tr>
<td>Reimbursement ratio</td>
<td>39.2</td>
<td>12.5 to 66.6</td>
<td>43</td>
</tr>
</tbody>
</table>

*Cumulative years (2005–2010)

| Total payments | 528  | 522 to 533 | 562  | 558 to 567 | 34  | 29 to 40|
| Total charges  | 1,854 | 1,844 to 1,864 | 2,025 | 2,015 to 2,036 | 171 | 157 to 186|
| Reimbursement ratio | 34.0 | 33.7 to 34.4 | 40   | 39.6 to 40.3 | 5.9 | 5.7 to 6.2|

*All means are adjusted for age, sex, race/ethnicity, education level, marital status, region, MSA, clinical classification, and survey year. Mean difference = Medicaid group mean–uninsured newly eligible mean. Uninsured newly eligible=uninsured individuals who will be Medicaid newly eligible with the Patient Protection and Affordable Care Act Medicaid expansion. Medicaid=individuals with Medicaid insurance. Total payments=sum of payments to treating physicians and facilities from out-of-pocket individual expenses and insurance payments. Total charges=sum of physician and facility charges. Reimbursement ratio=adjusted average of total payments divided by total charges per ED visit.

Total N for the 2-year sample is less than the sample size required for power=0.80.
RESULTS

- Adjusted payments per visit and adjusted charges per visit of uninsured Medicaid-ineligible group were not significantly different.
- Reimbursement ratios showed an additional reimbursement of 39% of charges for privately insured.
DISCUSSION

- Outpatient encounters compose 84% of ED visits
- After ACA implementation:
  - ED reimbursements for previously uninsured who gain Medicaid insurance increases by 17%
  - Moving Medicaid ineligible patients → private insurance through insurance exchanges may increase reimbursements by 39%
- States with most uninsured and potentially newly Medicaid eligible are also states that are rejecting Medicaid expansion
- Need to also consider decreased payments for unreimbursed care due to the ACA
  - Medicare disproportionate share hospital payments reduced by $22.1 billion in 10 years
  - Medicaid disproportionate share payments reduced by $13.6 billion in 10 years
- Limitations:
  - Only outpatient ED visits
  - Assumption of continuation of fee for service model
  - Insurance plans from exchange may have lower disbursements relative to current private plans
WHAT HAPPENS TO ED USE AFTER UNIVERSAL COVERAGE?

Annals of Emergency Medicine

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Episodes of Care: Is Emergency Medicine Ready?

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Episodes of Care: Is Emergency Medicine Ready?

- Bundled Payment aka Episodic payments: reimbursement based on expected costs for clinically defined episodes of care

Capitation

Fee-for-service
Episodes of Care: Is Emergency Medicine Ready?

Bundled Payments

**Advantages:**
- May discourage unnecessary care
- Coordination across providers
- Theoretically improves quality
- No penalty for sicker patients
- Transparency for patients
- Economies of scale

**Disadvantages:**
- Limited data on outcomes
- May not truly discourage unnecessary care
- May avoid patients that reimburse less
- How to set rates?
- Illnesses may not fall into “episodes”
- Research may be discouraged
CURRENT STATE

Table. Episodes of care being developed by PROMETHEUS and the American Board of Medical Specialties.

<table>
<thead>
<tr>
<th>PROMETHEUS</th>
<th>American Board of Medical Specialties</th>
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</thead>
<tbody>
<tr>
<td><strong>Procedure episode groupers</strong></td>
<td></td>
</tr>
<tr>
<td>Hip/knee replacement</td>
<td>Acute myocardial infarction for 30 days after onset; and postacute period (days 31–365 days postevent)</td>
</tr>
<tr>
<td>Coronary artery bypass graft surgery</td>
<td>Diabetes during a 1-y period</td>
</tr>
<tr>
<td>Cardiac catheterization</td>
<td>Chronic management of CHF during a 1-y period; and posthospitalization management of CHF during a 4-mo period</td>
</tr>
<tr>
<td>Bariatric surgery</td>
<td>CAD chronic management during a 1-y period; and CAD management postrevascularization during a 1-y period</td>
</tr>
<tr>
<td>Colon resection</td>
<td>Acute/subacute lumbar radiculopathy with or without lower back pain; and simple nonspecific lower back pain (acute and subacute)</td>
</tr>
<tr>
<td>Hernia repair</td>
<td>Community-acquired pneumonia hospitalization; and ambulatory pneumonia episode</td>
</tr>
<tr>
<td><strong>Disease condition episode groupers</strong></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>Asthma during 1-y period</td>
</tr>
<tr>
<td>CAD</td>
<td>Breast cancer 60-day period preceding breast biopsy; and treatment in newly diagnosed cases of breast cancer during a 15-mo period</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Stable COPD during a 1-y period; and unstable COPD during a 1-y period</td>
</tr>
<tr>
<td>CHF</td>
<td>Colon cancer 21-day period around colonoscopy; and treatment of localized colon cancer</td>
</tr>
<tr>
<td>COPD</td>
<td>GERD 12-mo period for treatment; and GERD 12-mo period of hiatal hemia treatment</td>
</tr>
<tr>
<td>Asthma</td>
<td>Acute/acute-recurrent sinusitis; and chronic sinusitis</td>
</tr>
<tr>
<td>Depression</td>
<td></td>
</tr>
<tr>
<td>Acute myocardial infarction</td>
<td></td>
</tr>
</tbody>
</table>

CAD, Coronary artery disease; CHF, congestive heart failure; COPD, chronic obstructive pulmonary disorder; GERD, gastroesophageal reflux disease.
CHALLENGES

- Cannot define a patient solely to 1 disease process, must recognize potential effect of comorbid conditions
- Most conditions are “ambulatory sensitive condition”
- ED care based on symptoms and may not have a definitive diagnosis
- Many see ED care as failure of system
- EMTALA mandates evaluation and stabilization of regardless of acuity of condition
- Limited involvement of ED physicians
Increased pressure on ED physicians to reduce resource use
Most emphasis on better transitions of care
Increased pressure from hospital administration against admissions and readmissions
Change in reimbursement model, may lead to trauma center closures
Expansion of large group practices or hospital employee models
RECOMMENDATIONS FOR EM

- Acute unscheduled episodic care cannot be accurately valued within an episode
- Emergency care should remain as fee for service
- Addition of incentives for better coordination of care
- Modeling of ED based episodes should include cost analysis and predictive modeling related to outcomes
- Overall, ED physicians need to become more involved in the process
Over the next decade, the ACA will change the landscape of healthcare

Expect increase in ED visits after full implementation, at least initially

Reimbursements may initially go up due to increased visits, but as payments models change, may go down

ED physicians need to become more involve in the national healthcare setting
For more info on the ACA

- Read the Bill
  http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf

- Kaiser’s summary