Oregon Health & Science University
School of Medicine

Scholarly Projects Final Report

Title *(Must match poster title; include key words in the title to improve electronic search capabilities.)*

Ensuring fair insurance reimbursement in the emergency department

Student Investigator's Name

Christian Hext

Date of Submission *(mm/dd/yyyy)*

03/17/2022

Graduation Year

2022

Project Course *(Indicate whether the project was conducted in the Scholarly Projects Curriculum; Physician Scientist Experience; Combined Degree Program [MD/MPH, MD/PhD]; or other course.)*

Scholarly Projects

Co-Investigators *(Names, departments; institution if not OHSU)*

N/A

Mentor's Name

Dr. John Moorhead

Mentor's Department

Department of Emergency Medicine

Scholarly Project Final Report

Concentration Lead's Name

Dr. Mark Baskerville

Project/Research Question

Is there a way to prevent downcoding in Oregon emergency departments?

Type of Project *(Best description of your project; e.g., research study, quality improvement project, engineering project, etc.)*

Public Advocacy work/Public Policy Project

Key words *(4-10 words describing key aspects of your project)*

Insurance; emergency department; billing; triage; downcoding

Meeting Presentations
If your project was presented at a meeting besides the OHSU Capstone, please provide the meeting(s) name, location, date, and presentation format below (poster vs. podium presentation or other).

Publications *(Abstract, article, other)*
If your project was published, please provide reference(s) below in JAMA style.

Submission to Archive
Final reports will be archived in a central library to benefit other students and colleagues. Describe any restrictions below (e.g., hold until publication of article on a specific date).

N/A

Scholarly Project Final Report

Next Steps
What are possible next steps that would build upon the results of this project? Could any data or tools resulting from the project have the potential to be used to answer new research questions by future medical students?

Having future medical students work to bring the ACEP sample downcoding bill to the Oregon legislature.

Please follow the link below and complete the archival process for your Project in addition to submitting your final report.

https://ohsu.ca1.qualtrics.com/jfe/form/SV_3ls2z8V0goKiHZP

Student's Signature/Date *(Electronic signatures on this form are acceptable.)*
This report describes work that I conducted in the Scholarly Projects Curriculum or alternative academic program at the OHSU School of Medicine. By typing my signature below, I attest to its authenticity and originality and agree to submit it to the Archive.

X
Student's full name

Mentor's Approval *(Signature/date)*

X
Mentor Name

Scholarly Project Final Report

Report*: Information in the report should be consistent with the poster, but could include additional material. Insert text in the following sections targeting 1500-3000 words overall; include key figures and tables. Use Calibri 11-point font, single spaced and 1-inch margin; follow JAMA style conventions as detailed in the full instructions.*

Introduction *(≥250 words)*

COVID has decimated the workforce and hospital balance sheets over the last two years. One of the 'front lines' of this pandemic as well as most social determinants of medicine is the Emergency Department. However, even during these challenging times, insurance companies have attempted to find ways to pay emergency physicians and hospitals less for the same amount of work. These policies are increasing already high barriers for emergency departments to provide high quality care for everyone who requires it.

For the last few years, insurance companies had trialed retroactive denials for patients who presented to the emergency department but were discharged with a nonurgent diagnosis. The Emergency Medical Treatment and Labor Act (EMTALA) is a federal law that stipulates that emergency departments cannot turn anyone away from the department until they have been examined and deemed to be at low risk of life or limb threatening injury. This also relies on the prudent layperson standard, which is defined by states and in Oregon is defined as a condition "that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would:" [1]

Therefore, retroactive denials in the emergency department were the perfect place for insurance companies to deny reimbursement from, because as long as a patient had a concern that *could be* life threatening, the emergency department was under the legal (and moral) obligation to provide them with a high level of care until potential pathologies were ruled out.

However, with the Consolidated Appropriations Act, 2021 now enacted into law, insurance companies were no longer allowed to retroactively deny coverage for patients. [2] This was good for patients, but insurance companies had already begun looking into ways to cut costs associated with paying for healthcare administration in the emergency department. This took the guise of retroactively 'downcoding' prior emergency department visits. When patients arrive at the emergency department, they are triaged. This means that patients are given a number determining the potential severity of the patient presentation (usually from 1, most severe to 5, least severe). Triage is a common method of emergency department workflow management which determines how quickly tests are taken, how soon the patient needs to be

[1] https://oregon.public.law/statutes/ors_743a.012

[2] https://www.congress.gov/bill/116th-congress/house-bill/133/text

seen by a physician, and what type of imaging needs to be done (and again, how quickly). Examples of level 1 triage include major accidents and 2 include chest pain which could be due to myocardial ischemia/ST segment elevations ('heart attacks'). The hospital is paid a certain amount for level 1 & 2's and less as the number goes down toward 5.

Downcoding entails looking at the initial triage code for a patient, and if the patient is later found to have a non-life threatening condition, then they are 'downcoded,' which means that the insurance company says that while they were triaged for chest pain at level 2 which determined a person should be seen quickly, but that person turned out to have GERD (or acid reflux), then they will retroactively reimburse for a triage of 4 or 5. This means that while the patient will now pay the same amount as they would have originally, physicians and hospitals are being paid less. While it is obviously advantageous that the federal No Surprises Act prevented patients from being stuck with a surprise bill, it is less advantageous that already strained rural hospitals are much more likely to be harmed by this. It also runs the risk that hospitals that are owned by private equity will view emergency departments (already less profitable than many other specialties due to EMTALA and being the safety net for the underserved) as a financial liability and further prune down financing offered. Furthermore, emergency physicians, who were on the front lines of the global pandemic, are likely to be reimbursed at lower rates. While some would counter that physicians are well compensated, this ignores the fact that emergency medicine physicians suffer some of the most severe levels of burnout, even prior to the COVID pandemic. If communities are to expect (as they should) continued high quality care from experienced physicians, then cutting the pay of people who have lived through traumatic events for over two straight years who were already burned out is the last possible option to help make sure there are emergency medicine physicians available.

The Oregon College of Emergency Physicians, before I had connected with them, discussed this issue with the Department of Consumer and Business Services which is responsible for insurance regulation, who stated that they were only able to adjudicate disputes between insurers and hospitals/physicians when the insurance company was refusing any payment. In other words, because the insurance company was paying *something*, there was nothing they felt they were able to do.

Methods *(≥250 words)*

To begin with, I asked around OHSU about physicians who were interested in policy. I was quickly connected with Dr. John Moorhead, who a mentor of mine when I asked, simply said "he's the guy you want to talk with." Dr. Moorhead is a long-serving advocate for his patients, emergency physicians, and the field of emergency medicine as a whole. When we first met via zoom, I explained my desire to prevent surprise billing due to retroactive denials. As this was well over a year ago, he mentioned that the federal No Surprises Act had been passed but not yet enacted. So while there were still reports of retroactive denials, these practices would be limited to the next few months. However, he mentioned downcoding and its effects on physician and hospital compensation.

While I was unaware where to start on this, he was more than willing to invite me to a board meeting of the Oregon College of Emergency Physicians, which just so happened to be extremely interested in the topic. I attended a meeting and realized that they had a dedicated reimbursement working group that was working on downcoding. Katy King, the governmental relations head of OCEP was also someone who worked closely with the statehouse on this and many other issues. One thing that OCEP as well as the American College of Emergency Physicians was working on was gathering data on how often downcoding was happening in both Oregon and in other states throughout the country. Currently, there is no firm data on the percentage of times this happens, there have been reports in Oregon of this happening most often with Moda Health, but downcoding had not yet seemed to become the default policy for every insurance claim. Potentially this was the same 'trial balloon' that insurance companies had floated when beginning retroactive denials. As the federal No Surprises Act went into effect, OCEP, ACEP, and other interested parties started to prepare for more downcoding events in an environment where the Department of Consumer and Business Services was refusing to step in.

I had begun to think that writing a bill could be helpful to pass in Oregon. But OCEP and ACEP as well as other state chapters had already begun the hard work of drafting a bill. I created a short amendment to the ORS (Oregon Revised Statute) to see if a short amendment would be easier to pass than the large bill during the short legislative session that ended in March 2022, as well as for my own learning.

Prior to matriculating in medical school I had been engaged in activism through various means. I had helped found community action groups in India which would petition local government officials, I had worked at the Indiana Civil Liberties Union (a state branch of the ACLU), I had worked on PR for local nonprofits, and I had worked on statewide political campaigns in Indiana while getting my masters in public affairs. I realized that political pressure both from concerned citizens to their state representatives as well as from legislators to the Department of Consumer and Business Services would be more likely to change the internal workings of DCBS. So I decided to help create a fact sheet for both individuals who were interested in policy as well as legislators who would require an introduction to the issue that did not require prior medical knowledge.

These fact sheets could be given through visiting congressional offices, but in order to reach the general public, or at least those who may be interested in this issue, further outreach would be required. As OCEP was interested in this topic, they were open to the idea of fielding the topic on their website as well as using their social media regarding it.

With that in mind I decided to create a 'social media toolkit' regarding the issue. To do this I created a series of sample tweets as well as a clear outline of both how to target subgroups of the population and what subgroups (those interested in healthcare policy, physicians, nurses, etc.) However, we would need to define what metrics meant success in a social media campaign as well as give people who engaged a tangible and simple task to help influence legislators. For this I created an 'ask,' which consists of a short

form letter describing downcoding and why preventing it is important where all they have to do is sign their name and email it to their representatives. I also included a website where an individual just needs to enter in their address to find the emails of exactly who to send it to.

I then realized that many others would be interested in this topic, and so identified other organizations who, when OCEP would begin this campaign, would reach out to to help amplify their message and the request to reach out to legislators.

I also created an email to go out to everyone who subscribes to OCEP's newsletters which is slightly more technical compared to outreach to the general public. And I created a sample press release to go out to reporters who may be interested in covering this topic.

Finally, I identified a list of statewide and local newspapers to whom OCEP could reach out to in order to publish an op-ed. The statewide newspapers would be a wonderful way to reach out to a large group of people, and the local newspapers could be targeted to reach members of the legislature who would most likely monitor their local papers closely.

Results *(≥500 words)*

N/A as not a research project.

Discussion *(≥500 words)*

One of the most interesting parts of this project was learning just how slow enacting change can be. Having worked in public affairs, I knew that this was the case, but I had never tried to work on enact specific legislation. At the ACLU I was tasked with running public relations against certain bills in Indiana and publicizing court battles that lawyers for the organization were engaged in, but passing legislation is much different than trying to stop it.

I was lucky to have been warned about this from board members at OCEP, they were clear that issues such as downcoding are large and complicated and require a long term view of solutions. It was clear that organizations like OCEP were on the front lines of a very protracted battle on many different fronts.

The most important takeaway for me was the idea that you will need to prepare over long periods of time to create legislation, political advocacy campaigns, and enacting change. Going into emergency medicine is planning to be exposed to many of those who have fallen through the cracks of society in various ways. In order to prevent burnout and feeling as if I'm not making a difference in the upstream problems that many

face, I am looking forward to continue working with advocacy groups throughout my career.

Conclusions *(2-3 summary sentences)*

This was a wonderful experience which taught me about the importance of finding potential allies in public policy. These people will often have experience in other aspects of policy and may have been working on similar issues.

Appendix A

Below is a 'bill for an act' which alters the ORS. Bolded is the additional text that I had added.

A BILL FOR AN ACT

Relating to healthcare insurance reimbursement to hospitals and doctors; amending ORS

Be It Enacted by the People of the State of Oregon

SECTION 1. ORS 743A.012 is amended to read:

743A.012 1(a)

As used in this section:

(1)(a)"Behavioral health assessment" means an evaluation by a behavioral health clinician, in person or using telemedicine, to determine a patient's need for immediate crisis stabilization.

(b) "Behavioral health clinician" means:

(A) A licensed psychiatrist;

(B) A licensed psychologist;

(C) A licensed nurse practitioner with a specialty in psychiatric mental health;

(D) A licensed clinical social worker;

(E) A licensed professional counselor or licensed marriage and family therapist;

(F) A certified clinical social work associate;

(G) An intern or resident who is working under a board-approved supervisory contract in a clinical mental health field; or

(H) Any other clinician whose authorized scope of practice includes mental health diagnosis and treatment.

(c) "Behavioral health crisis" means a disruption in an individual's mental or emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in an emergency department or admission to a hospital to prevent a serious deterioration in the individual's mental or physical health.

(d) "Emergency medical condition" means a medical condition:

(A) That manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would:

(i) Place the health of a person, or an unborn child in the case of a pregnant woman, in serious jeopardy;

(ii) Result in serious impairment to bodily functions; or

(iii) Result in serious dysfunction of any bodily organ or part;

(B) With respect to a pregnant woman who is having contractions, for which there is inadequate time to effect a safe transfer to another hospital before delivery or for which a transfer may pose a threat to the health or safety of the woman or the unborn child; or

(C) That is a behavioral health crisis.

(e) "Emergency medical screening exam" means the medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an emergency medical condition.

(f) "Emergency services" means, with respect to an emergency medical condition:

(A) An emergency medical screening exam or behavioral health assessment that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

(B) Such further medical examination and treatment as are required under 42 U.S.C. 1395dd to stabilize a patient, to the extent the examination and treatment are within the capability of the staff and facilities available at a hospital.

(g) "Grandfathered health plan" has the meaning given that term in ORS 743B.005 (Definitions).

(h) "Health benefit plan" has the meaning given that term in ORS 743B.005 (Definitions).

(i) "Prior authorization" has the meaning given that term in ORS 743B.001 (Definitions).

(j) "Stabilize" means to provide medical treatment as necessary to:

(A) Ensure that, within reasonable medical probability, no material deterioration of an emergency medical condition is likely to occur during or to result from the transfer of the patient from a facility; and

(B) With respect to a pregnant woman who is in active labor, to perform the delivery, including the delivery of the placenta.

(2) All insurers offering a health benefit plan shall provide coverage without prior authorization for emergency services.

(a) Reimbursement for services rendered and evaluation in the emergency department shall be determined by initial triage from emergency department staff and presenting symptoms and by emergency services received, not by final diagnosis.

(A) Disputes regarding payment levels between healthcare providers or hospitals and insurers shall be under the purview of the Department of Consumer and Business Services.

(B) Emergency services received as defined by 743A.012 section (1)(f)(B)

(b) Disagreements between providers or hospitals and insurers shall be adjudicated with the assistance of the Department of Consumer and Business Services

(C) The Department of Consumer and Business Services shall be entitled to adjudicate both disputes over nonpayment and decreased levels of payment.

(3) A health benefit plan, other than a grandfathered health plan, must provide coverage required by subsection (2) of this section:

(a) For the services of participating providers, without regard to any term or condition of coverage other than:

(A) The coordination of benefits;

(B) An affiliation period or waiting period permitted under part 7 of the Employee Retirement Income Security Act, part A of Title XXVII of the Public Health Service Act or chapter 100 of the Internal Revenue Code;

(C) An exclusion other than an exclusion of emergency services; or

(D) Applicable cost-sharing; and

(b) For the services of a nonparticipating provider:

(A) Without imposing any administrative requirement or limitation on coverage that is more restrictive than requirements or limitations that apply to participating providers;

(B) Without imposing a copayment amount or coinsurance rate that exceeds the amount or rate for participating providers;

(C) Without imposing a deductible, unless the deductible applies generally to nonparticipating providers; and

(D) Subject only to an out-of-pocket maximum that applies to all services from nonparticipating providers.

(4) All insurers offering a health benefit plan shall provide information to enrollees in plain language regarding:

(a) What constitutes an emergency medical condition;

(b) The coverage provided for emergency services;

(c) How and where to obtain emergency services; and

(d) The appropriate use of 9-1-1.

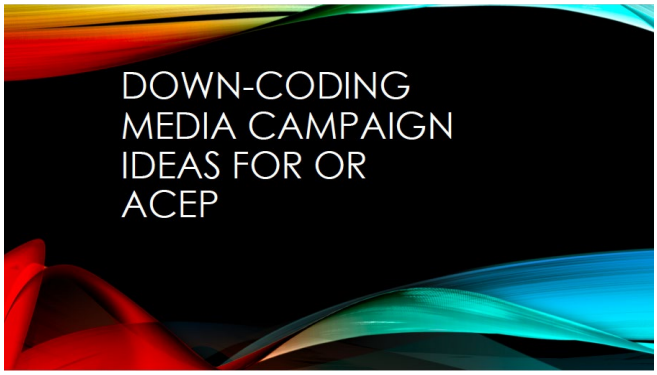
(5) An insurer offering a health benefit plan may not discourage appropriate use of 9-1-1 and may not deny coverage for emergency services solely because 9-1-1 was used.

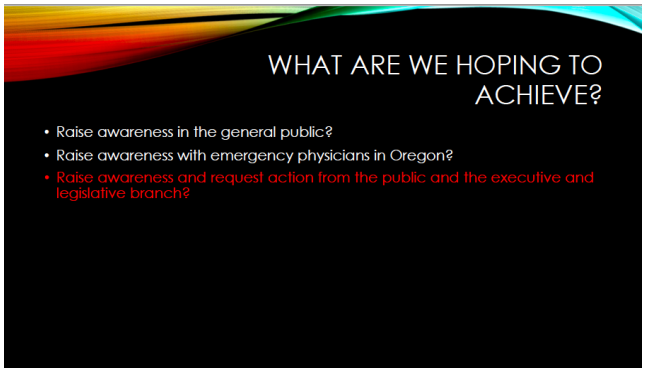
(6) This section is exempt from ORS 743A.001 (Automatic repeal of certain statutes on individual and group health insurance). [Formerly 743.699; 2011 c.500 §38; 2017 c.273 §4; 2019 c.358 §41]

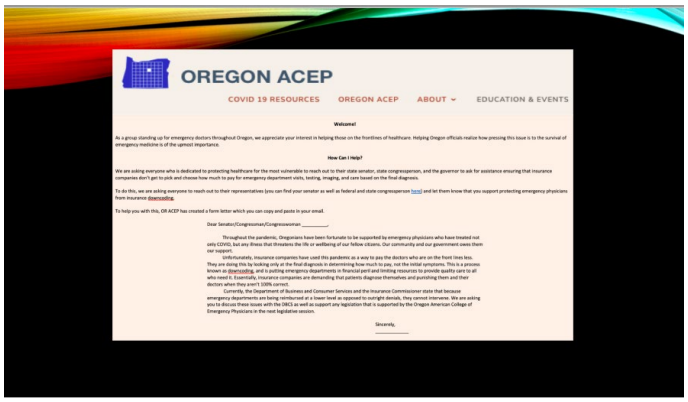
Appendix B

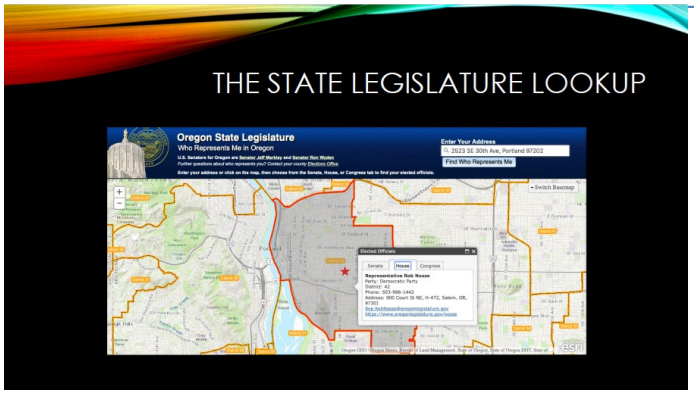
Below is a copy of a powerpoint delivered to OCEP including A sample letter for OCEP Members to send to

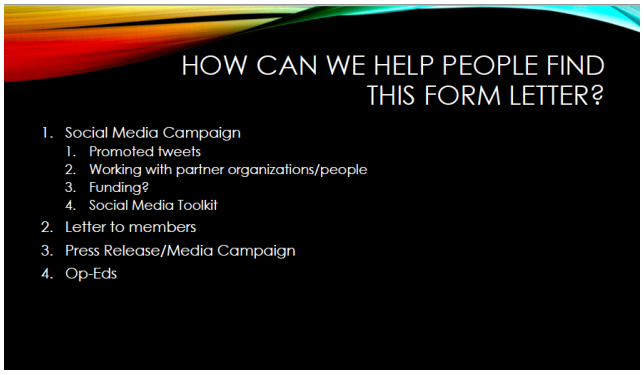
their legislators, a sample link in the OCEP website for determining where to send their letters, a social media toolkit, a list of organizations OCEP could potentially partner with, a sample letter for members of the public to contact legislators with, a sample press release to announce an 'anti-downcoding campaign,' a sample list of newspapers and journals to target regarding the need to change downcoding and a discussion on timing of any press release/campaign.



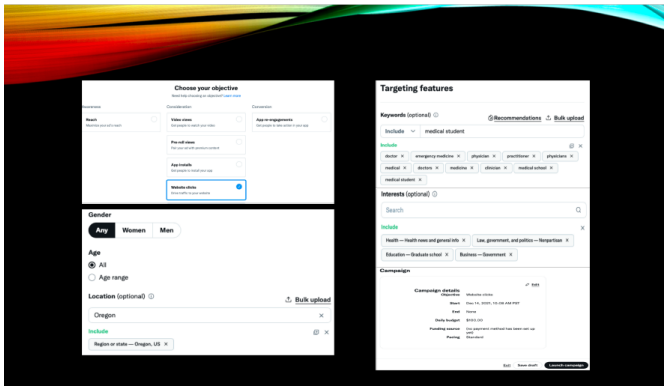




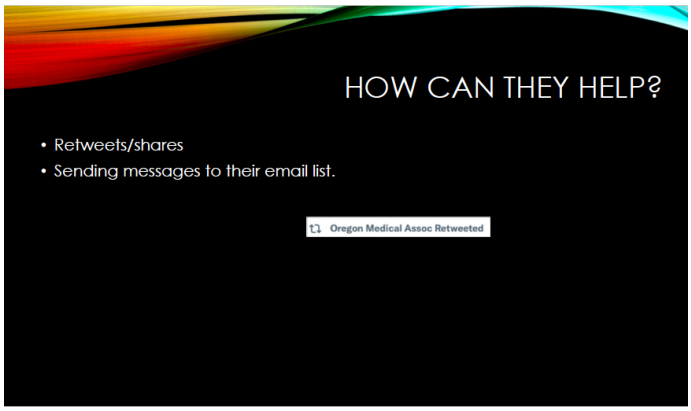

THE STATE LEGISLATURE LOOKUP
Oregon State Legislature
Who Represents Me in Oregon
Enter Your Address
Find Who Represents Me


HOW CAN WE HELP PEOPLE FIND THIS FORM LETTER?
1. Social Media Campaign
1. Promoted tweets
2. Working with partner organizations/people
3. Funding?
4. Social Media Toolkit
2. Letter to members
3. Press Release/Media Campaign
4. Op-Eds

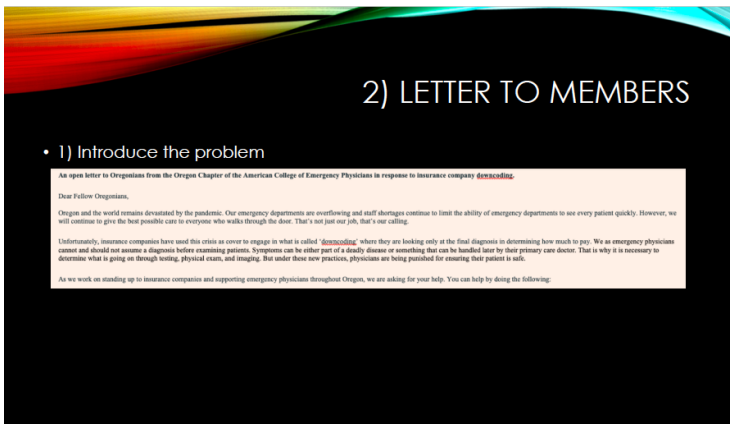

1) SOCIAL MEDIA CAMPAIGN
Oregon ACEP @oregonacep1 · Nov 23
Emergency Physicians have our back, now it's time for us to have theirs. Help us stand up to insurance companies who are trying to cut costs at the expense of patient care.
Find out how to help at
oregonacep.org/Downcoding


Choose your objective
Gender
Any
Women
Men
Age
All
Age range
Location (optional)
Bulk upload
Oregon
Targeting features
Keywords (optional)
Recommendations
Bulk upload
medical student
Interests (optional)
Campaign


WORKING WITH PARTNER ORGANIZATIONS AND PEOPLE
OREGON MEDICAL ASSOCIATION
OMA
MY EMERGENCY MY CHOICE
Oregon Association of Hospitals and Health Systems
OHSU
Dr. Glaucomflecken

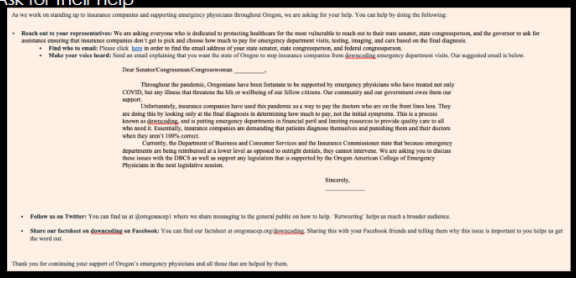

HOW CAN THEY HELP?
• Retweets/shares
• Sending messages to their email list.
Oregon Medical Assoc Retweeted


SOCIAL MEDIA TOOLKIT
• If desired, can come up with >10 suggested tweets and suggested timeline for posting and retweeting.


2) LETTER TO MEMBERS
• 1) Introduce the problem
An open letter to Oregonians from the Oregon Chapter of the American College of Emergency Physicians in response to insurance company downcoding.
Dear Fellow Oregonians,
Oregon and the world remains devastated by the pandemic. Our emergency departments are overflowing and staff shortages continue to limit the ability of emergency departments to see every patient quickly. However, we will continue to give the best possible care to everyone who walks through the door. That's not just our job, that's our calling.
Unfortunately, insurance companies have used this crisis as cover to engage in what is called 'downcoding' where they are looking only at the final diagnosis in determining how much to pay. We as emergency physicians cannot and should not assume a diagnosis before examining patients. Symptoms can be either part of a deadly disease or something that can be handled later by their primary care doctor. That is why it is necessary to determine what is going on through testing, physical exam, and imaging. But under these new practices, physicians are being punished for ensuring their patient is safe.
As we work on standing up to insurance companies and supporting emergency physicians throughout Oregon, we are asking for your help. You can help by doing the following:

LETTER TO MEMBERS CONTD.

- 2) Ask for their help



As we work on standing up to insurance companies and supporting emergency physicians throughout Oregon, we are asking for your help. You can help by doing the following:

- **Reach out to your representatives:** We are asking everyone who is dedicated to protecting healthcare for the most vulnerable to reach out to their state senator, state congressperson, and the governor to ask for assistance ensuring that insurance companies don't get to pick and choose how much to pay for emergency department visits, testing, imaging, and care based on the final diagnosis.
  - **Find who to email:** Please click here in order to find the email address of your state senator, state congressperson, and federal congressperson.
  - **Make your voice heard:** Send an email explaining that you want the state of Oregon to stop insurance companies from downcoding emergency department visits. Our suggested email is below.

Dear Senator/Congressman/Congresswoman _____,

Throughout the pandemic, Oregonians have been fortunate to be supported by emergency physicians who have treated not only COVID, but any illness that threatens the life or wellbeing of our fellow citizens. Our community and our government owes them our support.

Unfortunately, insurance companies have used this pandemic as a way to pay the doctors who are on the front lines less. They are doing this by looking only at the final diagnosis in determining how much to pay, not the initial symptoms. This is a process known as downcoding, and is putting emergency departments in financial peril and limiting resources to provide quality care to all who need it. Essentially, insurance companies are demanding that patients diagnose themselves and punishing them and their doctors when they aren't 100% correct.

Currently, the Department of Business and Consumer Services and the Insurance Commissioner state that because emergency departments are being reimbursed at a lower level as opposed to outright denials, they cannot intervene. We are asking you to discuss those issues with the DBCS as well as support any legislation that is supported by the Oregon American College of Emergency Physicians in the next legislative session.

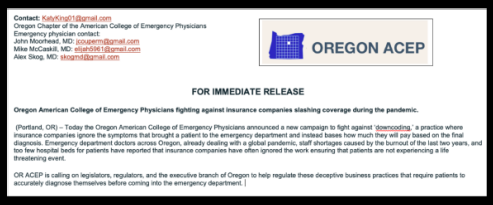
Sincerely,

_____

- **Follow us on Twitter!** You can find us at @oregonacep1 where we share messaging to the general public on how to help. 'Retweeting' helps us reach a broader audience.
- **Share our factsheet on downcoding on Facebook:** You can find our factsheet at oregonacep.org/downcoding. Sharing this with your Facebook friends and telling them why this issue is important to you helps us get the word out.

Thank you for continuing your support of Oregon's emergency physicians and all those that are helped by them.

3) PRESS RELEASE



Contact: KellyKing01@gmail.com
Oregon Chapter of the American College of Emergency Physicians
Emergency physician contact:
John Moorhead, MD: jcouperm@gmail.com
Mike McCaskill, MD: elliott0461@gmail.com
Alex Skog, MD: skogmd@gmail.com

OREGON ACEP

FOR IMMEDIATE RELEASE

Oregon American College of Emergency Physicians fighting against insurance companies slashing coverage during the pandemic.

(Portland, OR) – Today the Oregon American College of Emergency Physicians announced a new campaign to fight against 'downcoding,' a practice where insurance companies ignore the symptoms that brought a patient to the emergency department and instead bases how much they will pay based on the final diagnosis. Emergency department doctors across Oregon, already dealing with a global pandemic, staff shortages caused by the burnout of the last two years, and too few hospital beds for patients have reported that insurance companies have often ignored the work ensuring that patients are not experiencing a life threatening event.

OR ACEP is calling on legislators, regulators, and the executive branch of Oregon to help regulate these deceptive business practices that require patients to accurately diagnose themselves before coming into the emergency department.

4) OP-EDS

The Oregonian

The Register-Guard

PORTLAND BUSINESS JOURNAL

statesman journal

- There are 16 daily newspapers in Oregon
- ~92 Weekly/semi-weekly/monthly newspapers
  - Of these, could submit op-eds in papers serving influential legislators' district.

TIMING

- To maximize impact, will want to publish press releases, op-eds, social media campaigns, and direct outreach at the same time.