Emergency Department EDPMA Practice Management Association

April 3, 2020

The Honorable Alex M. Azar II
Secretary of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

RE: **CARES Act Implementation for America's Emergency Care Safety Net – Dedicated and Expedited Relief for Emergency Physicians**

Dear Secretary Azar:

The Emergency Department Practice Management Association (EDPMA) is one of the nation's largest professional physician trade associations focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups, as well as billing, coding, and other professional support organizations that assist healthcare providers in our nation's emergency departments. **Together, EDPMA's members deliver (or directly support) health care for about half of the 146 million patients that visit U.S. emergency departments each year.**

In these unprecedented times, we want to thank you for the decisive action that the Administration has taken thus far in response to the COVID-19 pandemic. As we have shared with you recently, emergency physicians are already experiencing the challenges associated with assuring the most appropriate emergency response in a time of crisis. Preserving the safety net for our nation's health care system is critical to lessening the impact of COVID-19, and will hasten our nation's recovery.

Emergency medical care is provided by emergency physicians in a variety of practice models. Most of the care in U.S. emergency departments is provided by groups of physicians that operate as business entities that are separate from the hospitals at which they practice.

As a direct result of the COVID-19 crisis, independent emergency physician groups (not employed by the hospital) are experiencing significant financial stress due to the following primary factors:

- Significant decreases in patient volume (estimated to average 30%).
- The need to sustain emergency readiness capabilities (as the nation's patient care safety net)
- Significant increases in costs, including

- The cost of maintaining the minimum physician staffing levels required for patient and public health needs.
- The cost of preparing for surge staffing and covering shifts left vacant by quarantined providers.
- Increased expenses to develop and implement alternative care sites, telehealth capabilities, purchase of PPE and new administration costs related to care during the COVID-19 pandemic.

In that light, Division B of the Coronavirus Aid, Relief, and Economic Security (CARES) Act includes the provision of $100 billion, via the Public Health and Social Services Emergency Fund (PHSSEF), "to prevent, prepare for, and respond to coronavirus . . . to eligible health care providers for ***health care related expenses*** or ***lost revenues*** that are attributable to coronavirus."

Proposal:

To ensure critical staffing in anticipation of COVID-19 related volumes, the formula below is proposed to provide critical funding to emergency physician provider groups. Fundamentally, the formula relies on previously reported publicly available data for reimbursement under the Medicare program. This data is applied as a standardized payment to mitigate the costs sustained due to retaining staffing levels in a period of low volume and lost revenue leading up to the peak of this crisis. This approach also allows funding for COVID-19 surge staffing levels that have to be committed and sustained in the volume periods to ensure readiness at the peak of the crisis.

We are asking that you immediately distribute to each emergency physician group a payment equal to 4 months of lost patient volume and increased expenses to address the COVID-19 crisis. The payment would be based on: (1) 30% loss in patient volume (using as a baseline the 2019 volume number that each group attests to in its application) plus (2) non-reimbursable and incremental costs for COVID-19 based on a 20% increase on the other 70% of patient volume.

Data:

The following are key elements of data supporting the proposal.

Approximate total number of annual ED visits in the US in 2020:
150,000,000 (estimate based upon 2017 CDC data)

Average number of ED visits per month in the US:
150,000,000 / 12 = 12,500,000

Average reimbursement per ED patient using 2018 Medicare payments as proxy:
$164.74[1]

Four Months of PHSSEF Support:

We believe it is imperative to swiftly provide assistance to emergency practices, but also to ensure that the Agency is not bogged down in an onerous process that prevents the support from reaching the providers who need it. We believe the calculation should be extrapolated to 4 months to ensure that the amount supports emergency standby capacity, lost revenues, and increased expenses during the most critical time of this crisis.

Calculations for the impact of 4 months of COVID-19:

Decrease in collections due to decrease in ED visits:
3,750,000 visits x $164.74 per visit x 4 months: $2,471,121,594

Increased expenses:
estimated @ 20% on remaining ED visits, including additional services:
$1,153,190,077

Total Decrease in Revenue and Increase in Expenses (total of the above):
$3,624,311,672

We previously requested that in implementing the application process for distribution of the PHSSEF that the Secretary create a "fast track" process for emergency medicine physician practices. In light of this, we write to further stress the speed with which this disbursement must occur in order to maintain the nation's safety net. We have attached our March 30, 2020 letter outlining the factors that are contributing to emergency medicine practices **healthcare-related expenses** and **lost revenues** that we believe form the underlying rationale for creating a specific process for emergency medicine practices. ***Once again, we are requesting that the Secretary implement a streamlined PHSSEF disbursement mechanism specifically for emergency medicine practices.*** We believe that this would help facilitate the assistance envisioned under the PHSSEF. This will provide an instant infusion of support to the two-thirds of the nation's emergency departments that are not staffed by hospital employees. This is consistent with the legislative language which states that the payments are to be made in the "most efficient payment systems practicable to provide emergency payment."

Sincerely,

Bing Pao, MD, FACEP
Chair of the Board, EDPMA

[1]*Average of payments for EM services per visit based upon CMS data for 2018*
Total RVUs = E/M RVUs x 1.10 (accounting for procedures and interpretations)
Average Amount Per Visit = Total RVUs x Conversion Factor = $164.74

The 2018 Medicare data from the BESS database, lists the volume of all emergency service evaluation and management codes performed by emergency physicians, Assigning the corresponding RVU(total) for each CPT code allows for the calculation of total RVUs paid by Medicare in 2018 for emergency service Evaluation and Management codes - 85,148,908. Evaluation and management codes account for 90% of Medicare payments for emergency physician services. The other 10% of emergency physician Medicare payments are for procedures performed. Adding 10% to the 85,148,908 RVU value yields total allowed Medicare RVUs of 93,663,798. Using the 2018 Conversion factor of $35.89, total Medicare allowable payments can be calculated. Dividing those payments by total 2018 Medicare volume, 20,405,077, allows for calculation of average Medicare emergency physician allowable payment per emergency service.

For 2018, the formula is thus: 93,663,798 (total emergency physician RVUs) X $35.89 (conversion factor) = $3,361,593,710 (total allowable payments)/20,405,077 (2018 Medicare volume) = $164.74Medicare allowable payment for emergency physician services.