Emergency Department EDPMA Practice Management Association

April 17, 2020

The Honorable Mitch McConnell
Majority Leader
United State Senate
Washington, D.C. 20510

The Honorable Charles Schumer
Minority Leader
United States Senate
Washington, D.C. 20510

The Honorable Nancy Pelosi
Speaker of the House
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Kevin McCarthy
Minority Leader
U.S. House of Representatives
Washington, D.C. 20515

RE: **COVID-19 Relief for Emergency Providers**

Dear Speaker Pelosi and Leaders McConnell, Schumer and McCarthy:

The Emergency Department Practice Management Association (EDPMA) represents independent emergency physician groups and their practice partners. Our members serve approximately half of all visits to emergency departments in the nation.

Emergency physicians are on the frontlines, risking their lives to care for COVID-19 patients and fight further spread of the virus. About two-thirds of emergency physicians are part of an independent physician practice, many of which are facing devastating financial consequences due to declining volume and the additional cost of preparing for a potential surge. And caring for pateints is much more time consuming due to new isolation procedures and PPE. We appreciate the first infusion of CARES Act funds distributed last Friday, but are concerned that (1) it is not nearly enough funding to cover the unique and additional needs of emergency physicians who are nation's safety net and (2)) the conditions attached to the funding would force emergency physicians to accept whatever reimbursement rate commercial insurers unilaterally choose to pay. There must be a mechanism to ensure that insurance pays fairly.

Therefore, we are asking Congress to pass legislation that would:

1) Require the immediate infusion of $3.6 billion in funds for emergency physician practices as described in the attached letters to the Administration,
2) Ensure that commercial insurers reimburse for emergency care at sustainable and commercially reasonable rates during and after the pandemic as emergency physicians willingly comply with the ban on balance billing,

3) Prohibit commercial insurers, ERISA plans, Medicaid managed care, and State Medicaid programs from engaging in prospective denials and down coding of emergency claims and ensure extensions for the timely filing of claims,
4) Provide for Hazard Pay for frontline healthcare workers,
5) For the Medicare Accelerated and Advance Payment Program: extend repayment periods, reduce interest charges, reduce the required percentage of future claims devoted to repayment, and ensure no prepayment penalties,
6) Expand medical liability protections,
7) Avoid expected future Medicare cuts and ensure positive annual updates,
8) Ensure Parity for Tricare and Medicaid,
9) Improve physician practice access to small business loans,
10) Expand telehealth flexibilities to ERISA plans,
11) Allow broader waivers of EMTALA, and
12) Allow Freestanding Emergency Centers to be reimbursed by Medicare and Medicaid during the pandemic.

(1) Immediate Infusion of $3.6 Billion for Emergency Physician Groups

As described in the attached letters, we asked the Administration to immediately distribute $3.6 billion of the $100 billion for healthcare providers to emergency physician to ensure that the safety net remains intact during the pandemic. To date, only a small amount (less than 10%) of this necessary funding has been distributed to emergency physicians. Although emergency physicians are on the front lines, risking their lives and health, and have significantly greater financial costs due to the pandemic, they were given the same amount of COVID-19 relief as other healthcare providers in the nation.

We urge Congress to pass legislative language to ensure that at least $3.6 billion is immediately distributed to emergency physician groups. This request is more than reasonable given:

(A) the proportion of the COVID-19 patients that emergency physicians treat,
(B) independent emergency physicians and their groups staff about two-thirds of the nation's emergency departments,
(C) although emergency physicians are only 4% of physicians, they provide over two-thirds of all uninsured care in the nation and over half of the Medicaid/CHIP care, and
(D) everyone visiting the emergency department is evaluated and stabilized no matter how little the insurance company covers or the patient pays.

We also ask that legislation ensure that emergency physicians receive additional funding in the future as needed given that the length of the pandemic may stretch much farther into the future. We believe that these funds will be used in important ways to protect patients, sustain clinician's availability for this emergency, and hasten our nation's recovery from this pandemic.

(2) <u>Ensure Sustainable and Commercially Reasonable Commercial Reimbursement for Emergency Care</u>

We strongly support efforts to ban balance billing; however, such changes must simultaneously ensure that commercial insurers reimburse at a sustainable and commercially reasonable rate or patient access to timely emergency care will be jeopardized and some emergency departments, especially in rural and vulnerable neighborhoods, may close down. The threat to access to care is even greater during the COVID-19 pandemic when many emergency physician groups are in dire financial straits while commercial insurers have higher profits because people are not experiencing as many illnesses or injuries as they shelter at home.

Yet, the terms and conditions for the attestation for COVID-19 relief funds puts emergency physicians in a catch 22. If they don't attest to a balance billing ban, they get no relief. Yet, if the emergency physician signs the attestation, they must agree to accept commercial reimbursement at whatever rate the insurance plan wants to pay. This is the same catch 22 that is the subject of considerable debate in Congress, as insurance companies attempt to gain an unbalanced advantage in discussions about fair payment for emergency services. Further, the attestation is ambiguous about exactly how long, to which patients, and to which care the balance billing ban applies.

This approach raises a number of concerns:

- There is good reason Congress has not passed surprise billing legislation even though all stakeholders - including EDPMA - agree that patients should not be balance billed. The controversy is not over prohibiting balance bills; the controversy is about how to ensure insurance companies reimburse at sustainable and commercially reasonable rates. That is the true battleground.
- The Administration has usurped Congress on this issue and has completely ignored the controversy. Through its COVID-19 provider relief attestation requirements, it prohibits balance billing and requires emergency providers to accept whatever rate the commercial insurer offers -- even if that reimbursement is not sustainable or not commercially reasonable.
- This problematic requirement may apply to reimbursement for ALL care, not just reimbursement for COVID-19 testing and treatment. A few days after distributing the funds "with no strings attached," the Administration attached one devastating string. The Administration updated its website a few days after the attestation was distributed and it now states **"Care does not have to be specific to treating COVID-19. HHS broadly views every patient as a possible case of COVID-19." This creates a very problematic ambiguity. <u>Does this mean that emergency physicians must promise to cover all gaps in the patient's insurance plan; not just gaps related to testing and treatment of COVID-19? Is balance billing for all emergency care prohibited if the provider accepts the relief funds? If the patient does not cover the patient cost-sharing, will the provider continue to cover this portion of the bill as well</u>**?
- Emergency physicians are facing dire financial circumstances due to the COVID-19 pandemic. They are not the cause of the pandemic, yet they are risking their lives. Even if

emergency providers could afford to cover the gap in the patient's insurance, the physician was not a party to the insurance contract and should not be burdened with covering the gaps.

- On the other hand, commercial insurers were a party to the contract and can afford to cover the gap in coverage. In fact, commercial insurers are covering significantly less care during the COVID-19 pandemic because more people are avoiding illnesses and injuries while they shelter at home. Commercial insurers have received a huge windfall of unexpected – and unearned – profit. **This is clearly not the time to shift tens of billions of dollars from emergency providers to commercial insurers.**
- If a provider signs the attestation, the commercial insurer has total and unilateral control over what it deems to be its "in-network" rate for emergency care. Unlike other specialties, there are rarely network adequacy requirements that set a minimum number of emergency physicians for the network because out-of-network emergency providers can provide the care. So, in-network rates for emergency care often do not reflect negotiated rates. **A plan's in-network rate can be unsustainable, not commercially reasonable, and may have been rejected by the vast majority of emergency providers in the geographic area. Yet, under the attestation requirements, the provider must accept this rate.** This is not only contrary to the tenets of a marketplace, it raises serious ethical issues because the provider is mandated by federal law to provide emergency care and is not ensured reasonable reimbursement for that mandated care.

Therefore, we urge Congress to pass legislation ensuring that commercial insurers reimburse for emergency care – during and after the pandemic - at sustainable and commercially reasonable rates by:

- **Requiring all commercial insurers to reimburse for emergency care at sustainable and commercially reasonable rates,**
- **Allowing providers to use accessible and unbiased dispute resolution - without any monetary threshold - if the reimbursement rate is not sustainable or not commercially reasonable,**
- **Ensuring that any payment standard cannot be manipulated by commercial insurers. This can be done by tying the minimum payment standard to the past, adjusted for inflation, and**
- **Ensuring that any payment standard does not reward bad payer behavior -- where the commercial insurer is not contributing its fair share to the inherent cost of the nation's healthcare safety net. This can be done by tying any payment standard to an independent, transparent, unbiased database approved by the state.**

(3) <u>Prohibit Prospective Down Coding of Emergency Claims by Commercial Insurers and Medicaid</u>

Commercial insurers, like United Healthcare, are planning to prospectively down code claims based on the final diagnosis without first reviewing the medical record. And some States, like Virginia, have passed legislation through which they plan to reduce Medicaid payments based on diagnosis alone.

These actions violate the important patient protection called the prudent layperson (PLP) standard. The federal PLP standard applies to Medicare, Medicaid, commercial group and individual plans, and ERISA plans. And 47 states have also adopted the PLP standard in state law. .

The Centers for Medicare & Medicaid Services (CMS) have clearly provided in rules and guidance that the federal PLP standard prohibits denial or down coding based on diagnosis without first reviewing the presenting symptoms (which are in the medical record):

"we prohibit the use of codes (either symptoms or final diagnosis) for denying claims because we believe there is no way a list can capture every scenario that could indicate an emergency medical condition under the BBA provisions. … The final determination of coverage ***and payment*** *must be made taking into account the presenting symptoms rather than the final diagnosis. The purpose of this rule is to ensure that enrollees have unfettered access to health care for emergency medical conditions, and that providers of emergency services receive payment for those claims meeting that definition without having to navigate through unreasonable administrative burdens."* (emphasis added to point out that both denials **and down coding** of emergency claims based on diagnosis is a violation of the federal prudent layperson standard) (quote from *Medicaid Managed Care Rule 2016*).

We wrote CMS with our concerns that a Medicaid MCO was violating the PLP by denying and down coding based on diagnosis. In Seema Verma's March 15, 2018, response letter, she wrote:

> "*Whenever a payer (whether an MCO or a State) denies coverage* ***or modifies a claim for payment,*** *the determination of whether the prudent layperson standard has been met must be based on all pertinent documentation, must be focused on the presenting symptoms (and not on the final diagnosis), and must make take into account that the decision to seek emergency services was made by a prudent layperson (rather than a medical professional).*

Commercial insurers are prospectively down coding claims to a lower level of care, denying separately reimbursable procedures by bundling charges, and denying claims that are not filed in a timely fashion. Unfortunately, emergency physicians simply don't have the resources to fight for correct payment, especially during a pandemic. Further, they cannot afford a delay in receiving full payment for the care provided. We urge you to pass legislation that clarifies that commercial insurers, ERISA plans, Medicaid MCO's, and State Medicaid programs may not prospectively deny or down code emergency claims. Like in Medicare, the claims should be paid in full and then audited if there are concerns.

(4) **Provide for Hazard Pay for Frontline Healthcare Workers**

Emergency departments continue to be the on the front lines of patient care during the ongoing pandemic. Emergency physicians and their practice partners are the definition of essential employees during the crisis, and as such, have been sacrificing their safety, and in some cases their lives, in order to ensure patients infected or potentially infected with COVID-19 receive

care. They are also at high-risk for infection from simply treating patients in need of traditional emergent care. EDPMA strongly endorses the current bipartisan discussions in Congress regarding the addition of hazard pay that would include essential, frontline health care workers like emergency physicians.

EDPMA appreciates various components currently being discussed for potential inclusion in the next COVID-19 response legislation, including but not limited to the hourly equivalency of significant annual pay increases through the end of the calendar year and a one-time per employee bonus to incentivize the recruitment of healthcare workers. As our members continue to sacrifice their safety and their families' safety, we fully support the inclusion of additional financial resources to provide them with the reimbursement that their service deserves.

(5) <u>For the Medicare Accelerated and Advance Payment Program: Extend repayment periods, reduce interest charges, reduce the required percentage of future claims devoted to repayment, and ensure no prepayment penalties.</u>

We acknowledge the speed with which CMS sought to infuse cash into practices that are struggling to provide services by expanding the accessibility of the Medicare Accelerated and Advance Payment Program. However, there are several key features of the program -- some of which are statutory in nature -- that must be changed in order for practices to truly be able to rely on the program for assistance.

First, ***EDPMA urges Congress to direct CMS to extend the date at which repayment begins and the length of the repayment period for physician practices.*** The way the program is currently structured, repayment (via garnishing of future submitted claims) begins within 120 days and must be completed within 210 days, at which point unpaid balances become due and are subject to an interest rate. It is not feasible for physician practices to take out a loan that transitions into repayment based on future claims submissions in 120 days when we do not know what the coronavirus environment will look like in 120 days. Likewise, given that the loan must be then paid off within 90 days of when repayment begins (or it is subject to a high interest rate), it is not clear in what environment we will be operating at the time the balance of the loans will become due if submitted claims to not cover the loan amounts. The commencement and length of the repayment period must be addressed.

In addition, ***EDPMA urges Congress to reduce the interest rate on unpaid balances from this program (which is currently set at 10.25%)***. This amount is extremely high and unfair to apply to practices in 210 days when we do not know in what state of the PHE we will be.

EDPMA also urges Congress to set a limit on the percentage (e.g. 25%) of a future submitted claim that can be apportioned to loan repayment. If Congress allows entire claims to be directed to loan repayment in 120 days, it will simply be postponing a cash flow crisis to a date in the future (when we do not even know that the PHE will be over).

Finally, after the crisis is over and operations stabilize, it is possible that some practices will seek to extinguish their loan liabilities prior to the repayment deadline. ***EDPMA asks that Congress***

ensure that there are no early payment penalties associated with the loans provided in the Medicare Accelerated and Advance Payment Program.

(6) <u>Expand Medical Liability Protections</u>

Emergency physicians on the front lines fighting the pandemic are also significantly at risk for liability. Our knowledge base and official guidance, from a wide variety of sources, is full of holes and constantly changing. And information is released as providers are busy treating patients. There are liability risks in delaying testing or care, inaccurate diagnoses, providing care outside the provider's normal practice area, providing care in unusual locations or through telemedicine, coming out of retirement or graduating early in order to help with the pandemic, having to ration care, and having inadequate personal protection equipment (PPE), testing kits or ventilators.

Congress has already passed section 3215 of the CARES Act, which includes important liability protections for healthcare volunteers and other providers in limited circumstances. However, more must be done to ensure that physicians can comfortably continue to provide care during the pandemic.

(7) <u>Avoid Expected Future Medicare Cuts, Ensure Positive Annual Updatesn</u>

First, ***we believe that one of the most straightforward steps Congress can take is to extend physician payment relief from sequestration cuts at least through calendar year 2021, if not longer***. While we had always opposed the sequestration cuts, now is certainly not the time to ask health care professionals to finance the federal budget through sequestration.

Second, in the calendar year (CY) 2020 Medicare Physician Fee Schedule (MPFS), the Centers for Medicare and Medicaid Services (CMS) finalized a series of proposals that would change the documentation guidelines and increase the relative value units (RVUs) for office and outpatient evaluation and management (E/M) services, as well as implement several new codes designed to enhance resources available to physicians providing office visits. These provisions were finalized with an effective date of January 1, 2021. These policy changes are expected to have a significant effect on the CY 2021 MPFS conversion factor due to statutory provisions related to budget neutrality, thus creating a massive downward impact on hospital-based specialties who are on the frontline of the fight against the COVID-19 pandemic. For emergency medicine, alone, the 2021 impact is estimated to result in a 7% cut!

It is imperative that Congress act immediately to protect the services and practices of those delivering patient care on the front lines of the current pandemic. While we recognize that office-based practices, and the patients that are treated in those settings, could benefit from the changes to the office and outpatient E/M policies, it would be irresponsible to penalize those working on the front lines of the coronavirus pandemic in order to pay for those policies. Therefore, ***EDPMA urges Congress to waive statutory budget neutrality requirements as they relate to the finalized package of office and outpatient E/M policies because of the disruptive effect implementation would have across all Medicare Physician Fee Schedule services during***

this time of crisis. Even if Congress does not intend to speed the implementation of these 2021 policies, it is important to waive these budget neutrality requirements for these policies *now* as practices grapple with providing services in our current environment so that the projected 7.0% 2021 cut does not loom over those practices already stretched thin.

Future pandemics are likely to become more common. This is not the time to ignore our nation's healthcare safety net. ***We believe Medicare rates should be updated for inflation.*** If this is not possible, Congress should at least create positive base payment updates in Medicare as it had originally done through 2019 in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The first quarter of 2020 has been incredibly tumultuous and the future is currently unknown. Supporting base Medicare reimbursements with a conversion factor update will help support practices as they navigate the rest of the PHE and, then, look forward toward a lengthy period of recovery.

(8) **Ensure Medicare Parity for Tricare and Medicaid**

W***e also urge Congress to pass a provision ensuring that, during the PHE, Medicaid and TRICARE payments have parity with Medicare claims***. These programs are a critical safety net that often have payment rates set that are known to require subsidization by other payers. Congress should ensure that payments in those programs achieve Medicare parity given that the cross-payer subsidization that those programs typically necessitate are not functioning at the normal levels during the PHE.

(9) Improve Physician Practice Access to Small Business Loans

We appreciate the swift action taken by Congress within the CARES Act to authorize and fund the Payment Protection Program (PPP) within the Small Business Administration (SBA). While the initial funding has assisted in keeping millions of Americans, including those employed by independent emergency medical practices, on employer payrolls, the impending depletion puts small businesses throughout the country in jeopardy. Without another urgent appropriation for the PPP, emergency physician groups may lack the resources to continue serving patients at this critical juncture. ***We urge Congress to allocate additional, robust funding to the PPP within the next COVID-19 legislative package***.

An issue that represents an impediment to patient access to emergency care is the inability to include certain employees when calculating the initial loan amount and subsequent loan forgiveness within the PPP. In particular, we are aware that some of our members relied upon previous guidance by the SBA regarding the treatment of independent contractors. That previous guidance led some of our members to believe that such payments would be eligible for both the initial loan and the loan forgiveness. Unfortunately, the SBA interim final rule (IFR) released on April 2 explicitly excludes independent contractors from an employer's calculation and requests that those independent contractors separately apply for the program. ***Therefore, we urge you to reconsider your stance for independent contractors (I/Cs), particularly I/Cs in medical practices who have reassigned Medicare receivables to the physician group with whom they are contracted.*** 1099s are expressly permitted to reassign Medicare receivables under the Social

Security Act to a physician group practice under certain Medicare requirements. Given the shortages of physicians generally and certainly in "hot spots" during this global pandemic, 1099 physicians have been a key aspect of physician group staffing models for decades and one of the reasons that Congress specifically authorized 1099 physician enrollment in Medicare in the Balance Budget Act of 2002. Or, at the very least, work to resolve any potential issues with entities who may have already submitted, or are in the process of submitting, loan applications with the previous understanding that payments for such entities would be included within this vital program.

Additionally, while our membership is made up of many small emergency physician groups, it is not unusual for some larger groups to employ over 500 FTEs spread out over multiple locations across the country. Because of this structure and the prescribed limitations of the PPP, many of these emergency departments are facing increasing financial hardship. In the CARES Act, Congress recognized that employers in the hotel and restaurant industry that have over 500 employees, but not over 500 *in a single location*, were eligible to participation in the PPP. ***EDPMA supports the inclusion of a provision in the next coronavirus response legislation that provides a similar exception for medical practices.*** Given the vital role that emergency physicians are playing in this crisis and the revenue stream crisis that many are facing, an exception for access to PPP funding is more than warranted.

Further it should be clarified that physician practices may both apply for loans and accept CARES Act healthcare provider relief.

10) Expand Telehealth Flexibilities to ERISA Plans

Congress has recognized the value of expanded telehealth/telemedicine services during this pandemic, with the authorization of a new CMS tool – the *Telehealth Services During Certain Emergency Periods Act of 2020* as part of the *Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020*. We also appreciate the CMS announcement on March 17 related to telehealth and the policies included in the interim final rule with comment (IFC) issued on March 30. However, there are still key gaps. In particular, we are concerned that all of the work that Congress, HHS, and CMS have done to protect patients and clinicians by expanding the accessibility of telehealth is limited by the fact that ERISA plans are not governed by the current rules. Therefore, ***EDPMA urges Congress to require ERISA plans to adopt the same telehealth flexibilities that improve access to telehealth care that were adopted by Medicare.***

11) Allow Broader Waivers of EMTALA

During an emergency, it will likely be prudent to redirect patients away from the emergency department and to select screening and testing sites. While we appreciate that HHS and CMS have provided guidance regarding EMTALA thus far, EDPMA urges Congress to make clear

that the Secretary of HHS has the ability to create a blanket waiver for all of EMTALA to allow localities the flexibility that they need to be able to provide care during this crisis.

12) **Allow Freestanding Emergency Departments to be Reimbursed by Medicare and Medicaid during the Pandemic**

Independent free-standing emergency centers (IFEC) are not directly owned by a hospital. As such, they are not recognized by CMS as eligible for Medicare or Medicaid payment for the technical component of services provided in IFECs. During a pandemic or natural disaster, hospital-based emergency departments can easily become overwhelmed and unable to care for, not only the patients suffering from the pandemic, but also all the other patients having non-pandemic life-threatening conditions. IFECs are fully equipped emergency departments staffed by Emergency Medicine trained physicians. During this time, all local resources should be available to patients, including IFECs, especially given that many of those facilities may have key healthcare resources (e.g., respirators, isolation rooms) to assist in caring for the patient overflow from hospital emergency departments. Therefore, ***we urge CMS to include a blanket waiver to allow for IFECs to receive full Medicare and Medicaid payments for both facility and professional services for all emergency care provided during the pandemic.***

Thank you for considering our requests.

Sincerely,

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

Cc Leadership of Congressional Committees

Emergency Department EDPMA Practice Management Association

April 8, 2020

Jim Parker
Director of Health Reform, Office of the Secretary of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave. SW
Washington, DC 20201
Jim.Parker@hhs.gov

Dear Mr. Parker:

The Emergency Department Practice Management Association (EDPMA) represents independent emergency physician groups and their practice partners. Our members serve approximately half of all visits to emergency departments in the nation.

We see that the first tranche of funding from the $100 billion CARES Act fund for healthcare providers, roughly $30 billion, will be distributed to providers immediately. While we greatly appreciate your office's immediate attention, we wish to point out that the distribution formula for the first tranche likely will not cover the unique and understandably greater needs of emergency physician groups. We urge you to ensure that the second tranche include the additional funding needed to cover the attached request at the allocated $3.6 billion for emergency physician practices. This support is absolutely critical for sustaining the nation's first line of medical care for this unprecedented pandemic.

Emergency physicians are fighting on the frontline of the pandemic, risking their lives and, at great expense, keeping significant staff on standby for the current volume of patients, as well as future, expected surges. The COVID-19 fund must ensure that independent emergency physician practices - who staff two-thirds of the nation's emergency departments - immediately receive adequate support or there may be dire consequences for the nation's ability to lessen the impact of the pandemic during these critical weeks. Failing to support these frontline clinicians will further risk the emergency care safety net. Supporting hospitals alone is not sufficient.

We are attaching our earlier correspondence where we recommend a formula for a streamlined payment to emergency physician groups. We urge you to immediately provide this recommended initial payment.

Thank you for all you are doing to assist in this critical time.

Sincerely,

Bing Pao

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

cc:
Laura Trueman
Gary Beck
Dheeraj Agarwal

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.