Emergency Department EDPMA Practice Management Association

March 24, 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 Response & Emergency Medicine**

Dear Speaker Pelosi and Leaders McConnell, Schumer and McCarthy:

In these unprecedented times of a WHO-declared global pandemic, the first Stafford Act emergency encompassing all of the United States, and a 319 public health emergency, emergency physicians are on the front lines of the response to COVID-19. As the canary in the coal mine, we can already foresee potential challenges in assuring the most appropriate emergency response to ensure the best care in the time of crisis. Patient access and accessibility to qualified healthcare professionals is foremost in our concerns. Given that, we ask that all Congressional action take into account the following three actions:

- *Enhance Resources Available to Treat Patients on the Front Lines*
- *Exclude Provisions that Will Slash Reimbursement to Crucial Emergency Departments*
- *Support Physician Services and Avoid Disruptions to the Medicare Physician Fee Schedule*

Enhance Resources Available to Treat Patients on the Front Lines

As Congress continues its consideration of legislative interventions to help communities address the COVID-19 epidemic, we humbly request leadership to consider the many contributions that practices make to ensuring the safe provision of care in addition to those we believe many members of Congress are only provided by hospitals. Many emergency physician groups providing care on the front lines in our country's emergency departments are independent practices, not direct employees of the hospitals to where much of the Congressional support is being directed. As we prepare for the surge of patients that we all expect are headed toward U.S. emergency departments in the very near future, ensuring that the physicians and practitioners

providing care in those settings have the resources to provide safe, effective care to patients is paramount.

Emergency practices are already feeling the impact of the readiness efforts. First, certain practices are expanding their call coverage, which directly increases costs. In addition, many practices are already procuring or attempting to procure their own personal protective equipment (PPE) because hospitals do not have adequate supplies and because it is expected that some care will be delivered outside of the four walls of hospital emergency departments. Two-thirds of all emergency department visits are currently handled by physicians in independent practices, thus representing a significant financial outlay to obtain PPE independent of hospital procurement. When we know with certainty that emergency physicians will be asked to perform patient care services such as intubation, practices are currently acting to ensure that their physicians have that PPE, and these efforts carry significant resource costs, both direct costs as well as FTEs to find and procure the PPE.

While in some cases, particularly to staff rural emergency departments, independent practices cover the cost of travel for their contracted emergency physicians. These travel expenses to ensure coverage of emergency departments through the country is increasing in light of the current pandemic. It is these and other pressures that are increasingly falling on the shoulders of independent emergency medicine practices, particularly in rural areas.

It is also important to highlight the direct consequences of maintaining the health of these physicians and practitioners. First, many physicians and practitioners working in emergency departments are self-quarantining themselves away from their families to ensure that they do not endanger their family members as well as to maintain the health of the providers themselves as a means of ensuring that we are able to staff emergency departments as the crisis worsens. In addition, independent practices are covering the housing costs of those physicians who have been exposed to the coronavirus. We expect that as the pandemic continues, these are costs that will continue to increase. In many cases, this requires separate housing, and independent emergency practices are covering the costs of that housing as part of being able to meet the needs of America's emergency system. While we believe it is the right thing to do so that we can provide the best patient care in our current crisis, these costs without support, combined with the near certainty that many members of our provider community will become ill and be unavailable to treat patients, will nonetheless begin to chip away at efforts to maintain our workforce, potentially limiting our system's ability to serve patients at this moment when they need this care the most. There are stories all over the country where this is happening. We are aware of a group in a small, rural setting that has had to rely on third year family practice residents because all of the other physicians are quarantined. We cannot ignore what has already started to surface across the United States.

Because of these investments being made by individual practices, ***we believe it is imperative that Congress consider support of emergency department efforts just as it has considered support for hospitals.*** We fully endorse efforts to support hospitals to make sure that they are ready for the surge and able to develop their standby capacity as we await the peak of the pandemic. However, Congress must recognize that in the emergency department setting that many of those costs are also incurred by the independent emergency practices and will need similar support.

Exclude Provisions that Will Slash Reimbursement to Crucial Emergency Departments

Emergency departments have adopted an "all hands on deck" approach during the current global health crisis, with physicians triaging and treating patients infected with COVID-19 while constantly putting their own lives at risk. During this critical time, policy makers must ensure that access to emergency care remains a priority in any legislative response. As you know, Congress has considered several proposals in recent months to end the practice of surprise insurance gaps, almost all of which would result in deep cuts to the reimbursement of emergency physicians. This not only includes doctors that must bill for out-of-network care, but also those who have negotiated in-network contracts with insurers. In fact, the Congressional Budget Office (CBO) recently found that using a median in-network benchmark payment rate for out-of-network care, a hallmark of various legislative approaches, would result in a 15 to 20% reimbursement cut to all physicians. While we appreciate the work being done to improve these proposals, we feel the current crisis is an inappropriate time to move forward with any solution that lowers reimbursement rates for physicians fighting the coronavirus on the front lines.

Prior to the current pandemic, emergency departments were already facing challenges in serving as the nation's healthcare safety net. Emergency physicians make up only 4% of overall physicians nationwide, yet they provide over 67% of all uninsured care and over 50% of Medicaid and CHIP care. As insurers continue to raise copays and move to high-deductible plans, a greater percentage of "allowed amounts" are never collected by emergency departments. Moreover, many private insurers are involved in the predatory practice of automatically downcoding or denying emergency claims based on final diagnosis rather than care provided, violating the Prudent Layperson Standard. A recent study[1] conducted by RAND found that, if a median in-network benchmark rate was applied to out-of-network hospital-based reimbursement, negotiated in-network payment rates would drop by up to 30%. The study estimated that the resulting gulf in reimbursement created by this policy would strip $94 million annually from in-network reimbursement of hospital-based physicians. The study also noted that "[a] policy that reduces hospital revenues to an extent that results in hospital closures or lower quality of care would not be in the best interest of patients." Considering this, it is important to recognize that rural hospital closures have soared in recent years, with over 110 shutting their doors to patients since 2010.

With all of this in mind, ***EDPMA urges Congress to exclude any provision in a pandemic response package aimed at resolving out-of-network billing disputes that would cut physician reimbursement at a time when patients are relying on them most***. EDPMA has consistently stood with patients and the broader medical community in advocating to remove patients from out-of-network billing disputes between insurers and physicians. During this time of crisis, congressional leaders must ensure that the physician workforce is bolstered with timely, consistent reimbursement in order to help guarantee patient access to vital emergency care.

Support Physician Services and Avoid Disruptions to the Medicare Physician Fee Schedule

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

[1] https://www.healthaffairs.org/do/10.1377/hblog20200320.866552/full/

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. In addition to these sweeping changes, the policies 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 those specialties that do not submit a significant number of claims for office and outpatient E/M services. For emergency medicine alone, this 2021 impact is estimated to result in a -7.0% 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 cuts do not loom over those practices already stretched thin.

Sincerely,

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