Future of Emergency Medicine – Payment

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The new challenges of the Covid-19 pandemic are layered on top of existing reimbursement head winds faced by emergency medicine and the fraying safety net of our healthcare system. Emergency physicians care for patients up front, and then ask for payment later. Fees are not collected upfront like most physician offices, planned procedures and diagnostic studies. We treat every patient and wear the white hat of EMTALA with pride. There are, however, some challenging economic consequences to this valiant practice, as insurers reimburse based upon negotiated rates and, retrospective analyses, meaning that charges are rarely reimbursed in full. At this point in time, 60-80% of our patients are reimbursed below our break-even point.

With such a large percentage of our patients reimbursed below our breakeven line, we must rely on private payers to support our practices, and, in fact, support the heath care safety net of this country. While this cost shifting is long standing, it has been exacerbated overtime. However, private payers have proven to be progressively more wary of their role in addressing ED deficits through cost shifting.

The COVID-19 pandemic has brought some of the unfavorable implications of cost shifting into light. For instance, the drug Remdesivir (Gilead Sciences) has a world-wide price of $390 per dose for developed countries, yet US private insurance companies pay $520. That 33% price difference accounts for discounts to US government health care programs, that are then subsidized by the private insurance payment.

Prior to the 2010 Affordable Care Act (ACA), all physicians had the option to either negotiate a fee structure with an insurer (in-network) or to remain out-of-network. While the ACA provided health insurance to 15 million Americans, the Act also introduced the 'greatest of three' (GOT) for Emergency Medicine out of network (OON) services The GOT regulation imposes an obligation on payers to pay out-of-network emergency service providers the greatest-of-three payment amounts: (1) the amount the insurer pays in-network providers for the same services; (2) the amount calculated by the insurer to be the "usual, customary, and reasonable charges" for such services; or (3) the amount that would be paid under Medicare for such services. If the parties cannot agree on an amount, the insurance company frequently pays the average contracted rate, an amount based upon a non-transparent process, effectively limiting the bargaining power of both in and out-of-network physicians. Additionally, publicly available information indicates that some insurers have started to terminate in-network providers that may have high contracted rates, driving down the median payment for those left in-network.[1]

Out of network services also offer the option to balance bill the patient in the approximately 20 states that do not have a comprehensive or partial restriction on OON billing.[2] Health plans coined the misleading term 'surprise medical billing' for this out-of-network balance billing, and the press seized on this false narrative, depicting the situation as vulnerable patients being taken advantage of by greedy doctors, with little mention of the excessive profits reaped by insurers. This problematic misalignment between the interests of insurers and patients has especially been evident during COVID-19,

UnitedHealth Group (parent of United Healthcare and Optum) posted Q2 2020 profits of more than $2.2 billion per month or $110 million dollars profit per business day, during the worst economy since the Great Depression.[3]

A recent JAMA study suggested the prevalence of out of network represented over 40% of medical practices, however the figure is likely less than 10% for the vast majority of emergency medicine group practices.[4]

Over 135 million people are covered by ERISA health insurance, which historically reimbursed EM groups at somewhat higher levels.[5] Any out-of-network legislation will need to address those

plans as they are generally regulated at the Federal level. The federal ERISA statute contains "pre-emption" provisions which are liberally used by the health plans when states enact unfavorable legislation that they oppose, arguing that the federal law "pre-empts" the state law compliance.

The COVID-19 relief laws known as Families First and The CARES Act mandate that the health plans must reimburse medically necessary COVID testing; in addition, AHIP members also announced that they would reimburse COVID treatment in the ED and via telehealth at a rate between the cash rate (gross charges) and a negotiated rate. However, there exist no mechanism for negotiation, no database, no reference standards and no dispute resolution process, if there is disagreement. In fact, as a condition to retaining CARES Act provider relief funds (PRF), clinicians were required to agree not engage in OON balance billing for COVID testing and treatment. Nevertheless, the EM clinicians render the necessary and mandated treatment and are reimbursed at whatever amount the insurers want to pay—in fact many are now sunsetting their voluntary agreement to reimburse for COVID treatment between now and December 2020. But from a public policy perspective, as the payers further reduce payment, the safety net is more frayed and may ultimately fail.

Physicians, health plans and of course consumer groups all agree that patients must be taken out of the middle of reimbursement disputes for acute unscheduled emergency care. The leading Federal bills include these and other important patient protections. The methodology for determining the health plan's "initial" reimbursement and "independent dispute resolution" (IDR) process/procedure are the main areas of contention between the physician community and health plans. The Congressional Budget Office (CBO) estimated these federal bills could result in physician reimbursements declining $22 Billion over 10 years and 80% of the savings would come from a lower in network rates.[6] The RAND Corporation suggests that the losses would be substantially higher, in the range of 30% or $56-$107 billion per year.[7] It is estimated that there could be a 20 to 30% decline in commercial reimbursements from federal bench benchmarking without meaningful access to dispute resolutions.[7]

There are 3 conditions that need to be met to sustain the safety net 1.) a fair reference standard to serve as a data set 2.) a minimum standard payment for each service and 3.) a dispute resolution or IDR process. There has been some progress with a reference rate and the standard payment amount, at least in a few states. New York and Texas both utilize the Fair Health database as a basis for their reference rate. Additional states utilizing a reference data set known as an "All Payor Claims Database" (APCD) include Virginia and Washington. There have also been experiences with successful independent dispute resolution processes. In New York there were there were over 28 million emergency department (ED) visits between 2015 to 2018. In 2018, .0113% of ED clinician claims were determined in IDR (849 out of 7.5M ED visits according to the NY Dept. of Financial Services Report in 2019). Anecdotal evidence from EM groups shows that health plans are willing to negotiate reasonably and that in the rare case that a claim is determined in IDR that participants were generally satisfied. In addition to the New York model discussed above, Texas has new OON legislation that protects patients and provides a process for dispute resolution. Texas Dept. of Insurance (TDI) preliminary report of the first six months after the new law was implemented Jan. 1, 2020 shows the following favorable results: 1. Claims informally settled before IDR have averaged at over 4 times the initial payment; 2. Claims determined in IDR have averaged over 5.3 times the initial payment; 3. Emergency physicians have filed 85% of the IDR requests.[8] Georgia also has a similar law based on the Texas model that will go into effect next year and is currently subject to administrative rule making.

In the next few years there are likely to be reductions in Medicaid reimbursements. As unemployment increased during the pandemic, there was a substantial increase in Medicaid covered lives from the newly unemployed who originally may have had COBRA but then converted to Medicaid in states that expanded Medicaid or to self-pay in states that have not expanded. A study by the Economic Policy Institute estimates that 12 million Americans have lost their employer sponsored health insurance since February 2020.[9] The net impact of insurance loss on reimbursement is that ED groups commercial covered lives as a percentage of paying patients has declined, been replaced by Medicaid at lower rates or by self-pay where collection percentages are in the mid to high single digits. Therefore, the traditional cost shifting that has defined the emergency medicine business model for decades—shifting revenue received from commercial payors to cover the costs of the uninsured and under-insured-- will be further challenged. The answer to that challenge is meaningful and accessible IDR under federal law for reimbursement disputes, based on models similar to those in NY, TX and GA.

MIPS/ MACRA

The Merit-based Incentive Payment System (MIPS) is part of MACRA (Medicare Access and CHIP Reauthorization Act) and is one component of the Quality Payment Program. It replaced the Sustainable Growth Rate formula for setting professional fees for Medicare providers, that if fully implemented, would have resulted in a 20% to 28% cut to physician reimbursement for the care of Medicare beneficiaries. Unfortunately, MACRA created a more complicated quality

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program (MIPS) layered on top of traditional Medicare fee for service model and added financial risk linked to performance.

One of the central concepts within the Merit Based Incentive Payment System (MIPS) is escalating yearly requirements, making it more difficult to avoid penalties or receive a bonus. In 2021, 50 or 60 points will be needed to avoid a penalty, which means potentially 45 points must come from Quality, as ED providers are not in control of the measures related to cost and are typically exempt from the Promoting Interoperability requirement. As a result, even after obtaining 15 points from Improvement Activities, they need 30 points from the Quality category of MIPS. Centers for Medicare and Medicaid Services (CMS) scores the top six measures, and typical ED physicians would need to generate five MIPS points from each of those measures for 2020. The choice of measures is shrinking, as many of the Quality measures have 'topped out' and been retired. ACEP's Clinical Emergency Data Registry (CEDR) is positioned to promulgate new measures and will be essential for future success in MIPS.

The 2017 report from the Medicare Payment Advisory Committee to Congress recommended the elimination of MIPS, citing the reporting burden of $1.3 billion and the inability to compare clinicians due to its complex rules and provider exclusions depending on location, practice size, and other hardship factors. Dr. Don Berwick, former CMS administrator warned "if we don't get quality right, it is going to be all about cost" is becoming a more likely scenario as the reality of implementing a quality measurement program for physicians falters.[10]

There are alternatives to MIPS reporting under MACRA, including participation in qualified programs such as Advanced Alternative Payment Models (APMs) and Center for Medicare and Medicaid Innovation (CMMI) programs. Hospital-based physicians also have the option to use the scores of their facilities in place of reporting on MIPS level measures. Furthermore, CMS has not shown a commitment to the MIPS program. In 2020, CMS added only 4 quality measures and 2 quality improvement programs, while it retired 42 measures and dropped 75 quality improvement programs. The only areas of expansion were the number of episode-based class measures and the number of specialty-specific cost measures which increased from 8 to 18 and 39 to 45, respectively.[11]

Most recently, in response to the pandemic, CMS applied the 'automatic extreme and uncontrolled circumstance' policy for MIPS eligible physicians for 2020. Under this exemption, physicians will receive neither a bonus nor penalty in 2022. CMS stated goal remains to move payment beyond fee-for-service to APMs that shift financial risk on to the providers who are expected to manage the costs of care.

The newest CMS proposal creates new Medicare Value Pathways (MVP) as an intermediary program between MIPS and APMs. These pathways represent mini-bundles of care for specific conditions or procedures. The details of this program remain unclear and will likely be clarified in the 2021Proposed Rule for the Physician Fee Schedule. The MVP was created to limit reporting burden, simplify participation, increase the value of performance data, and include measures related to the patient experience of care. On a practical level, the program also addresses the problematic diminishing supply of quality measures, as the cost of creating these measures represents a significant obstacle to their implementation. These pathways include a predetermined subset of measures and activities that are related to a clinician scope of practice and integrated across specialties. CMS believes the pathway program be able to drive participation more cohesively when fully implemented. The pathways will provide meaningful data to clinicians about their clinical practice specialty or public health priorities, in alignment with key concepts outlined in ACEPs Acute Unscheduled Care Model (AUCM) that includes four such bundles. This model includes components such as quality measures, and a methodology for calculating cost using administrative data.

All Medicare policy is defined by Congressional actions and interpreted by the executive branch. Therefore, the election and executive shift makes predicting the future of ED reimbursement difficult. As there is a change in administration and the leadership in the Senate, broad health care legislation may occur early in 2021. That legislation may address the challenges of sustaining any health care payment model in the post-Covid world including a move to expand Medicaid or to lower the age for Medicare eligibility at the macro level. At the micro level, it may include increased payments for care coordination and continues the inclusion of EM reimbursement codes for telehealth. If policymakers choose to include new models of reimbursement for acute unscheduled care, they may create MVPs for symptom-driven conditions or incorporate AUCM-like models into other programs It is entirely likely that the independent physician reporting program MIPS is likely to be modified or allowed to sunset.

Alternative payment models

There is a growing unfavorable pressure on our current fee-for-service system. To summarize points mentioned already, emergency medicine continues to face decreasing reimbursement from commercial payers, we anticipate increased enrollment in

Medicaid and the self-pay population given recent rise in unemployment, systems currently allow for a downward trend in reimbursement for out of network care and we are experiencing increasing difficulty in complying with MACRA requirements.

However, just as there are downward pressures on fee-for-service reimbursement, there are new avenues to gain financial benefit by participating in APMs. Through MACRA, there is an increasing emphasis on high value care by rewarding those who provide care for relatively low cost of care as compared to their peers, while continuing to maintain high quality performance. In addition, MACRA provides a pathway to avoid having to participate in the onerous process of measuring and reporting quality measures altogether if your group participates in APMs in a significant way. Of note, the minimum requirements for "significant" participation in APMs continue to rise as well. For example, whereby in 2020 submission year participants are exempt from the quality measure requirements if they receive 50% of their Medicare payments (or 35% of Medicare patients) via an APM, in 2021 that minimum jumps to 75% of Medicare payments (or 50% of Medicare patients). Given the fact that current APM options are not easily accessible to the average emergency medicine practice group, ACEP has been forward-thinking in developing an emergency medicine APM framework, which will help transition our specialty into the future healthcare system.

Alternative payment models provide a structure for incorporating technology and telehealth into our practice. With these tools, APMs provide the structure by which we can expand our practice outside the four walls of the ED. Emergency medicine needs to own the care of our patients after the point of discharge, which will in turn reduce the total cost of care in our EDs. COVID-19 has been an accelerant to this process.

One APM created by ACEP, AUCM, is viewed favorably by CMMI and CMS, but at the moment has not yet been made available to emergency physicians. It may be tested by CMMI at some point, or more likely, may be incorporated into other APMs by including characteristics from AUCM. There is some hesitancy from payors, CMS included, in structuring an AUCM-like contract with an emergency practice group around total cost of care, especially when there are hospital systems contracts that look at the same total cost of care.

As a transition to participating in APMs, emergency physicians can immediately move to implement value-based contracts based on the components of APMs, particularly with Managed Care Organizations (MCOs), commercial payers, or even hospital partners. These components of value include resource utilization, post-ED care management or healthcare system navigation, and ultimately improving ED patient disposition decisions. Resource utilization and post-ED care management are the easiest components to incorporate into current practice. For example, working with a payer on value-based programs in these components might include decreasing variance among providers in the use of advanced imaging or providing a warm handoff to an MCO's care management staff after their enrollees' ED visits. Payers are equally interested in assistance with post-ED healthcare navigation, such as providers reaching out to discharged patients with the goals of decreasing ED recidivism and ensuring appropriate next "touch" with the healthcare system. From the hospital partner standpoint, emergency physicians can certainly provide value through encouraging follow up care with in-system providers. Although perhaps the most advanced component of APMs to implement, payers and hospital systems alike also find value in the disposition decisions emergency physicians make all day, every day. For example, hospital partners value appropriate utilization of bed type or nursing resources according to preset guidelines. Payers value avoiding unnecessary hospitalizations, which could certainly be done with the aid of a safe-discharge tool and paired with the above-mentioned post-ED healthcare navigation assistance.

ACEP must continue to play an integral role in moving emergency physicians into the future of APM participation. Emergency physicians need data and resources to analyze that data in order to move into the new payment systems. ACEP's CEDR is an important tool for participation in MACRA, and it can evolve along with the specialty by providing resource utilization and disposition data by provider. In addition, an analysis of current practice of Medicaid enrollee disposition from the emergency department by chief complaint, just as the College did with Medicare enrollees, could provide the means toward safer discharge and applications of APMs for the Medicaid population as well. Finally, ACEP needs to help expand emergency medicine participation in APMs beyond Medicare by continuing to provide advocacy with all payer types (public, commercial, or even hospital system partners) and by supporting emergency physicians at the local level who participate in these novel value-based contracts.

Group level adjustments

Under a traditional Fee for Service model, there are only a few factors emergency physicians can manipulate to adjust their profits: provider productivity, labor costs, minimizing overhead expenses or subsidies.

The structural challenges we have discussed thus far were in place before COVID-19 arrived. In the months preceding the

pandemic, large and small groups experimented with various strategies in attempt to optimize staffing, for instance adjusting ratios of physicians and advanced practice providers and reducing pay to providers.[12] The arrival of the COVID-19 pandemic caused surges of patients in hardest hit areas and, yet, paradoxically caused an overall drop in ED patient volumes (ranging from 25-40%).

The operational changes implemented prior to COVID-19 for productivity and labor cost optimization have left individual groups with very few options to maintain a positive bottom line. In some cases, those patients still coming to Emergency Departments will be sicker and the higher RVU's per patient will mitigate some loss in volume, but not enough to make up for the overall decrease without significant structural changes to physician compensation. In some instances, the only viable options to stabilize provider income under Fee for Service includes reducing provider hours, cutting pay to providers, obtaining subsidies or even walking away from existing contracts.

In previous times of challenge, there have been large contract management groups that could assume the cost of underperforming contracts, but many of those entities are heavily burdened with leveraged debt. Hospitals are also less likely to assume these contracts as many have been hurt financially by the loss of elective procedures, and do not see the employment of physicians as a financially optimal undertaking.

There are many who hope that ED volumes will return to pre-COVID levels after the pandemic passes. Much of the federal financial relief is based on this belief, despite a paucity of supporting evidence. The Federal financial COVID-19 relief has bypassed most front-line emergency physicians and gone directly to hospitals, and often not shared with contracted groups.

We find ourselves in uncharted territory. The metrics by which we could previously assess contracts and determine if operational changes can save them may no longer be relevant anymore. If reimbursement is continually driven down, recruitment of highly qualified residents may be more difficult, particularly those beginning their careers with hundreds of thousands of dollars of educational debt and the prospect of lower salaries. If higher salaries are linked to productivity, there may be a threat to patient safety, particularly when the remaining patients are sicker and more complicated than in the past.

During Covid19, we have utilized telehealth, and the data from this experience will be useful in arguing that the Emergency Allowance should continue. However, longer term we need effective models that we can package together for payment. These should include payment for EMTALA-related services and stand-by costs. There is a short window to develop major legislation around these new payment models, as well as out-of-network legislation prior to the next administration.

Moving out of an RVU system will be difficult, but it's hard to get value recognized if you drill down on the practice expense component. There is some standby cost recognized and some recognition of the care we provide to the uninsured recognized in the practice expense.

A lot of the changes will likely occur at the state level with innovative payers, and it will only take a few payers to make the transition. Dealing with larger payers such as Blue Cross or United Healthcare may not be as fruitful. The transition period between primarily FFS and alternative models will require a mechanism for financing. ED groups that are already heavily leveraged may have difficulty maintaining payroll while these options mature.

Effect of Covid

There is a need to understand the cost, monetary and lives lost, of the patients who did not come to the ED during Covid. The drop of 25-40% of our volume might suggest that those patients did not need care. However, this may reflect patients who needed, but did not receive, care. There is likely an impact, yet to be felt, from that loss of care.

Covid has been a terrible pandemic for our nation and our specialty. Our colleagues have been infected, have suffered and have died. Some are literally not sleeping in the same rooms as their spouses. But because of emergency physicians and the emergency care team, the safety net has held. Our future will never be brighter and our value never more recognized than right now. We are the tip of the spear within the house of medicine. Not one shift went unstaffed, every patient got treated. Nobody was turned away. Now we need adequate revenue to maintain the safety net and maintain the sharpness of the tip of the spear. ■

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