IEPC

Independent Emergency Physicians Consortium

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In this issue:

Lessons Learned

From the Pandemic for Emergency Medicine

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As emergency medicine recovers from the COVID-19 pandemic, the specialty cannot overlook all the changes that occurred over the last two and a half years. What emergency medicine practices can do is move forward with a greater sense of stability about their futures and financial standing with the right processes, protocols, and technological solutions in place. This article explores four core areas that were impacted during the pandemic, with recommendations for how emergency medicine practices can address the changes in 2022 and beyond.

Volume Changes

It is important to assess and evaluate the volume metrics of emergency medicine practices prior to the pandemic. This includes volume statistics as well as the associated staffing and payment parameters that were in place at the time. As the pandemic initially took hold on the U.S., emergency departments began seeing a decline in volume, with some visit volumes declining 40-50-60%, or even higher compared to pre-pandemic levels. The need for analytics, and particularly predictive analytics to swiftly adjust to these visit level changes required access to data 24/7/365. The use of data access and analytics was not solely to adjust staffing of attending emergency physicians and advanced practice providers, but it was also needed to stay financially agile as cash flow monitoring became imperative due to the drastic declines in volume.

As the pandemic continued, telehealth became the preferred treatment in some emergency departments, but also for the primary care networks and retail healthcare giants who now plunged full-bore into the space. Today virtually every healthcare retail giant, i.e., CVS, Rite-Aid, Walmart and Amazon have made public their intentions of targeting emergency departments' low acuity patients. Their intent is to suggest this patient category does not need emergency department care. Also notable is the same retail giants are developing programs to care for chronically ill patients. It may behoove emergency medicine practices to evaluate and decide whether they want to retain lower acuity patients, dubbed by some as the "bread-and-butter" of the specialty. Continued slow and/or no response may leave the specialty without some measure of this patient volume as others are moving very quickly to capture them, with enticements centered around care, when and where you want it.

In a hypothetical analysis of a 120,000-visit emergency department being reimbursed across the board at Medicare rates, if all 99281, 99282 and 25% of 99283 visits were lost, it would cause a $600,00+ financial loss. At a loss of all 99281, 99282 and 50% of 99283 patients, the loss becomes $1.2M .

Regarding traditional Medicare patients seen in U.S. emergency departments, this author analyzed Medicare data from 2016 through 2020. Summary findings include the following:

1. There is an across-the-board, i.e., emergency physicians, physician assistants, and

nurse practitioners decline in 99283 Medicare patients.

2. Among emergency physicians there is slippage for 99284 patients, with increases in 99284s for both PAs and NPs.
3. As per point #2, there is a similar pattern for 99285 patients for all three provider types.
4. There is an across-the-board, i.e., emergency physicians, physician assistants and nurse practitioners increase in 99291 patients.

These findings make it important to carefully monitor both volume and acuity mix shifts, as both shifts have the potential for significantly impacting the finances of our practices.

Acuity Mix Changes

As the pandemic evolved and emergency department volumes dropped, acuity levels shifted dramatically toward higher levels of care. Coupling these changes with volume changes posed major challenges for many emergency medicine practices and presented them with the same need of accessing their practice data and analytics 24/7/365. This need remains today as the specialty edges back toward a steady state, leveraging data and associated analytics as core tools for effectively and efficiently managing the practice.

Payer Mix Changes

Historically the payer mix of emergency medicine practices has been consistently stable. Additionally, focusing on the self-pay mix these patients have historically been no-pay. The combination of two factors changed both of these scenarios, and the emergence from the pandemic forecasts even more changes to anticipate and prepare for going forward.

First, the Affordable Care Act initially gave more patients secured insurance coverage than in prior decades. Second, the continuing explosion of patients being insured by high deductible plans has brought about an entirely new image of the self-pay, emergency department patient. Today, self-pay patients covered by high deductible plans are not "no-pay" patients, and, they are paying patients IF they are approached and engaged using technological processes and tools. Patients have become much more sophisticated in how they will engage and what solutions are appropriately presented to them. Finally, monitoring reports that continually inform practice executives about what is working and not working will ensure more patient payments.

Today's patients expect an Amazon-type consumer experience, with some preferring traditional paper statements, some text options, some email, some "live" call center options, and others a hybrid of all of these options. Success in engaging these patients requires the technology and reporting of changing patient preferences. Otherwise, there is risk in patients filing complaints to hospital administration for deficient follow up protocols and/or, at minimum, delays in their payments with the associated increase in a practice's accounts receivable and slowing of cash flow.

As we emerge from the pandemic, it will be imperative to scrupulously monitor the practice's payer mix. The door that provided substantial funding through the pandemic is starting to close, which will cause shifts in the practice mix. It is possible that millions of people will lose their coverage, and the transition to getting coverage again may be a lengthy process. These changes in the payer insurance mixes of emergency medicine practices are discussed in many current industry publications. It will be important to monitor these mixes looking for shifts to and from Medicaid; to and from employer-based insurance coverages and straight shifts to traditional self-pay. The latter shift could become permanent for some patients, while for others, the shift to traditional self-pay may be transitory. As noted above there is also shifting occurring within the traditional Medicare mix of patients. This requires close tracking as patients increasingly consider Medicare Advantage programs. This latter shift additionally requires close attention to potential contracting options for practices.

These shifts will need to be quickly identified and addressed as the potential for both cash flow and bad debt impacts cannot be missed. Engaging today's patients "where-they-live" means using the right approaches and techniques that today's emergency medicine patients are demanding and requiring. It is a very different world today, where respect for patients' preferred modes of communication and interaction are paramount. Older legacy processes and platforms for patient engagement no longer fit the needs of today's patients and are too risky for successful emergency medicine practices.

Compliance

It is always imperative for emergency medicine practices to be supported by a strong

LESSONS LEARNED

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compliance program, and with the increasing incidence of cyber-attacks on hospitals, insurers and physician practices, external certifications are becoming increasingly more important and significant. Revenue cycle management relies on SOC-1, SOC-2, PCI-DSS and HITRUST certifications to support and protect our emergency medicine practices.

The SOC reference refers to "Service Organization Controls." The SOC-1 and SOC-2 certifications are issued by the American Institute of Certified Public Accounts. SOC-1 certification involves an outside audit of all core revenue cycle management processes that impact a practice's financial reporting. SOC-2 certification focuses on the organization's non-financial reporting controls as they relate to data security, availability, processing integrity, confidentiality, and the privacy of the revenue cycle company's system. PCI-DSS certification is likewise an outside audit of all processes surrounding credit card processing. HITRUST certification is a third-party certification that represents the "gold standard" of protection today. These certifications are very well respected by hospital c-suite executives, giving them added assurance and comfort with their emergency medicine practice partners.

In sum, as the specialty emerges from the pandemic, the lessons learned for emergency medicine practices include being fortified with unlimited data access, on all devices, 24/7/365, inclusive of predictive analytic reporting. Practices must take care and

scrutiny of volume and payer mix shifts that cannot be missed, as well as being bolstered by outside certifications that provide both the practice and its hospital partners with more assurances and security. The industry and entire healthcare landscape is changing very quickly, and the specialty must continue to embrace the challenges and adapt appropriately to the changes.

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HEALTH PLAN'S NEW DIRTY TRICKS

Written by John Wallace, MD
President, IEPC

Anthem Health plan initiated a practice of "no pay" for ER diagnostic E and M code 99285 for discharged ER patients sometime in 2020. That the Health Plan's new Dirty Trick, simply not pay anything. Ironically, while the health plans are committing fraud, they are accusing the doctors of fraud.

Anthem has referred Emergency Physician (EP) groups to their Special Investigations Unit and placed them under prepayment review to justify its behavior which is contrary to California Health and Safety Code Section 1371.35(a). California law requires health plans to pay the uncontested portion of each claim where emergency services have been rendered. Anthem argues they are not required to pay the claim, because of billing fraud, or alternatively that these are incomplete claims since there is a disagreement about the coding of the claim. However, a disagreement over coding, or even miscoding, does not constitute fraud or misrepresentation. Nor does including other services conducted in conjunction with a visit (eg. billing for an EKG read along with billing for the medical workup of a cardiac case), described as inappropriate unbundling, constitute fraud. The EP groups not coding to Anthem's satisfaction is not fraud.

Similarly, a complete claim under 28 CCR § 1300.71 requires there to be sufficient information provided for the plan's claims adjudicator to determine the plan's liability. It contemplates that the physician will submit their information and the plan will independently determine their liability. In no way does it require that the physician code the claim to the satisfaction of the payer to be considered a "complete claim."

The arguments made by Anthem that EP groups are submitting fraudulent or incomplete claims are preposterous.

Anthem appears to be targeting small independent EP groups vs large multi hospital groups and including patients in coverage categories regulated by all: DOI, DMHC, ERISA and Medicare

DIRTY TRICKS con't from last page

Advantage. Although, there is one large group that reported nonpayment by Medicare Advantage claims. The pattern of nonpayment is feared to be spreading from California small groups to a national trend and attack on emergency physicians.

While Anthem and Government regulators have met with impacted groups and California ACEP multiple times, the result has been extremely frustrating, and no payments have been issued for services already rendered. Legal recourse for OON Groups is available through litigation (see below case details) and multi-party lawsuit has been assembled. In network Groups are precluded by their contracts from litigating and instead must arbitrate.

Anthem's longstanding tactics to force ER Groups to accept low in network rates and efforts to avoid payment for ER services already rendered were chronicled in the March 2018 IEPC Newsletter: David vs Goliath: IEPC challenges Health Plan behemoth Anthem Blue Cross regarding unfair Provider contracting practices.

What can emergency doctors do? Groups can fight back against health plan dirty tricks by joining the lawsuit or submitting data to California ACEP. No all groups can afford litigation, but data sharing is essential in this fight.

Plaintiffs vs. BLUE CROSS OF CALIFORNIA,
Case no: 22STCV05625
Legal Counsel: Buchalter and Associates
aselesnick@buchalter.com

Emergency Department Billing Data
Collate all Level 5, 99285 discharged with zero pay from Anthem.
Submit to California ACEP executive director, Elena Lopez Gusman
elopez-gusman@californiaacep.org

Thanks to Elena Lopez Gusman, California ACEP Executive Director in assisting with the preparation of this article.

SURPRISE LAWSUITS ON NO SURPRISES ACT

Written by John Wallace, MD President, IEPC

The No Surprises Act (NSA) was signed into law Dec. 27, 2020, by the President, as part of the $1.4 trillion Consolidated Appropriations Act, after years of negotiations. The surprise after NSA was passed was legal action against NSA as well as a surprise attack in cutting physician reimbursement.

When the NSA was passed, regulations were promulgated by the Department of Health and Human Services to implement the law, and which attempted to establish a Qualified Payment Amount (QPA) in stark contrast to the one established by the statute as passed by Congress.

Six Lawsuits were filed against the Tri Departments of HHS, Labor and Treasury, the first filed by the Texas Medical Association and Dr. Adam Corley in Tyler Texas on October 28, 2021. They contended that the NSA interim rule was inconsistent with the law and that statutory provisions required that the Independent Dispute Resolution (IDR) "shall consider" additional factors for QPA other than "median in network rates" regarding payment decisions for physician services. The suit further contended that the QPA Presumptive Policy should be vacated, and that the Tri Departments violated the Administrative Procedure Act (APA) in issuing an interim final rule prematurely without a Notice of Proposed Rule Making (NPRM) with a 60-day comment period before issuing the final rule.

Similar contentions and lawsuits were filed by Air Ambulance Association, AMA and AHA filed suit in DC federal court. ACEP/ACR/ASA filed in Chicago Federal Court. Georgia ACEP and the Medical Association of Georgia filed in Atlanta Federal Court. A similar case was filed in New York Federal Court.

The positive verdict came out on February 23, 2022, at Texas Federal Court in favor of the Plaintiffs which vacated the September Interim Final Rule and returned the case back to the Tri Departments for corrections. CMS on 2/28/22 withdrew guidance documents based on the September rule that were invalidated by the Texas Federal Court.

SURPRISE LAWSUITS con't from last page

In some states, health plans have cut physician payment rates by 20-30% to re-negotiate contracted rates. They set their own arbitrary payment rates.

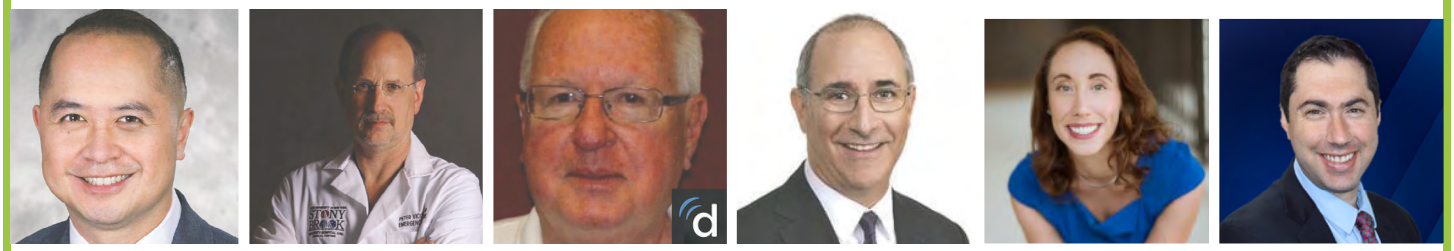
ER Groups need to monitor health plans compliance with NSA and how Out Of Network (OON) payments compare with pre-NSA OON payments and submit 30-day notice of negotiation for cases that qualify for Federal Independent Dispute Resolution (IDR).

As of January 2023, the Health Plans must publicize in and out of network allowable rates, which will help minimize their unilateral and arbitrary payment of what they think emergency physicians are worth.

What can emergency doctors do to fight against pay cuts from the NSA? Data.
Data is power. Emergency physician hope to document the disparity between claims payment before and after NSA.

Contact your billing company and request data for the QPA project. Here is sample language:

"I am writing to authorize (fill in the name of the independent RCM or internal RCM function of the hospital) to produce and report (fill in group name) data and complete the spreadsheet for the QPA Reporting Project." Since there is no PHI included, there is no need for secure transmittal. Send the completed survey templates with the name of your practice (Excel spreadsheets) to ACEP/ EDPMA consultant, Greg Hufstetler, at pahufs@comcast.net.



2022 IEPC SPEAKER SERIES
FREE TO ALL FRIENDS OF IEPC!

Presented by the Independent Emergency Physicians Consortium
Time & Date: 9:00AM - 9:30AM PT on the fourth Monday each month.

Membership in IEPC is not required to attend. Advance registration for the meeting is required. After registering, you will receive a confirmation email containing a link to join the call. This free speaker series welcomes leaders in the field to cover timely and engaging topics that are important to independent emergency physicians. The sessions will precede each monthly conference call and are open to all IEPC members and those who may be interested in joining.

- **July 25** - Andrew Young, MD, MPH, Medical Consultant, CA Dept. of Health Care Services to present Medi-Cal Update: State Initiatives to Improve Quality of Care
- **August 22** - Peter Viccellio, MD, FACEP, Associate CMO, University Hospital to present Making Room for Patients - ED Turnaround Times
- **September 19** - James Keaney, MD MPH FAAEM to discuss Institute for Justice in Emergency Medicine
- **October 24** - Andrew Selesnick to discuss the Anthem Lawsuit
- **November 28** - Laura Wooster, ACEP Associate Director, Public Affairs and Jeffrey Davis ACEP Director of Regulatory Affairs to share ACEP updates

Visit www.IEPC.org for more information and to register.

IEPC Members in the News

Andrew Fenton, MD, FACEP was elected Chief of Staff at Queen of the Valley Medical Center serving nearly 400 medical staff members. Queen of the Valley is a full-service diagnostic and therapeutic hospital with 191 licensed acute care medical beds that employs over 1,200 people. Dr. Fenton is a partner of Napa Valley Emergency Medical Group which has provided acute care to the Napa community since 1974, and was one of the founding groups of IEPC.

IEPC Speaker Series Welcomes Sheree Lowe

IEPC is proud to present the 2022 Speaker Series! This free speaker series welcomes leaders in the field to cover timely and engaging topics that are important to independent emergency physicians. The sessions will precede each monthly conference call and are open to all IEPC members and those who may be interested in joining.

In May, IEPC welcomed Sheree Lowe from the California hospital Association to discuss updates and insights for the future.

This series is presented on the fourth Monday of the month January - November. Advance registration is required and can be completed by registering through the monthly email invitation. After registering, you will receive a confirmation email containing information about joining the meeting.

Watch the interview with Sheree here!

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