EmCare Review of Cooper working paper

Updated

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Current Billing Challenges:

We agree that there is a problem with our current healthcare reimbursement system. Patients are caught in the middle of a commercial dispute between payors seeking to reduce the medical costs incurred by their insureds and providers seeking fair compensation for medical services provided to those insureds. Whether it is through a payor's refusal to contract with providers at a reasonable rate or leveraging narrow networks, the balance of power in the current system rests with the payors, creating a challenging environment for providers to negotiate reasonable reimbursement rates for services. If fair reimbursement rates cannot be negotiated, then providers have no other option than to bill for services on an out-of-network basis.

With the growth of high deductible health plans and payor driven narrow networks (a benefit design that purposefully excludes a significant percentage of the hospitals in a market and/or physicians who provide services in those markets), increasingly patients do not understand their health insurance benefits and often underestimate the financial impact of obtaining healthcare services. These issues are exacerbated in the emergency services context because typically patients do not have an opportunity to confirm their benefits before seeking emergency treatment. Care in emergency departments is regularly provided without the patient or the provider knowing whether the patient has insurance coverage for the services provided, much less whether the patient is in or out-of-network. Unlike other medical specialties, hospitals and physicians providing emergency services provide care to all patients regardless of insurance coverage or their ability to pay.

EmCare's Quality of Care:

EmCare's aim is and has always been, to provide the best possible and most efficient care to patients who come into our emergency departments. We take pride in providing high-quality care to our patients while improving clinical quality and supporting the goals for operational improvement sought by our hospital and health system partners. Our physicians are board-certified, highly qualified clinicians, and we maintain staffing levels in our emergency departments that provide high-quality care, shorten wait times and improve patient experiences in the emergency department. We believe the enhanced patient experiences and reputations of the emergency departments we operate makes them more attractive to potential patients and results in patients with more severe medical conditions seeking treatment at the emergency departments we operate rather than seeking treatment from alternative providers.

Based on benchmarking studies such as the 2015 Medicare Acuity Distribution for Emergency Department Codes, our physicians and clinical specialists deliver care that exceeds national standards. The Cooper paper states that there were increases in both billing for certain treatment codes, and for

patient admissions when EmCare began providing services at the hospitals included in the paper. There are many factors that impact the proper coding for treatment and admission rates, and our data shows that increased coding severity and admission rates are the result of changes in the severity of the medical conditions of patients seeking treatment. The incidence of billing for the codes referenced in the paper and the patient admission rates at hospitals where EmCare provided emergency services are below, not above, national benchmarks.

We are confident that the care provided by our clinical teams is medically sound, focused on comprehensive, high-quality care, and adheres to our robust internal coding and compliance controls to ensure compliance with federal and state regulations. We expect our physicians to use their best medical judgment in determining the course of treatment for their patients and inform EmCare's compliance team in the event they are ever pressured to admit patients or order tests when they do not think it is medically appropriate.

Network challenges:
We share others concerns about the increased financial burden that the healthcare system is placing on patients. Out-of-network billing issues have developed over time as a result of a number of factors. These are structural issues affecting the delivery of healthcare services across multiple specialties and provider types. In addition to providing emergency care, emergency departments are the primary source of primary care and urgent care for many patients. Emergency providers are caught between patients who need medical care and payors seeking to reduce the medical costs incurred by their insureds. Emergency services providers are obligated to provide care to patients even if the patient's insurer has refused to contract with the provider, and payors are using this obligation to their advantage.

With the proliferation of high-deductible health plans since the rollout of ACA, patients do not understand their benefit plans and significantly underestimate the financial impacts. It is imperative that we move the patient out of the middle of the financial model.

The out-of-network issue did not develop overnight; several complicating factors need to be considered to tell the full story.

In the emergency setting, hospitals and physicians are required to provide care to anyone, regardless of ability to pay as mandated by the 1986 Emergency Medical Treatment and Labor Act (EMTALA). No other medical specialty has this type of requirement. Since its inception, emergency medicine has become the primary care center for many patients. We can inform them of the financial responsibility that may come from being seen in the emergency setting, but we are required by law to provide care. Hospitals are in the same situation.

In addition, several developments have unfortunately exacerbated the out-of-network problem, including:

Since 2010, when CMS released its interim guidance and set up the "Greatest of Three," out-of-network payment formula for emergency physicians, the impact created a no-win situation for patients. The "allowed amounts" from payors saw major shifts away from the plan portion to the patient's portion of the allowable amount.

With the enactment of ACA, we are seeing a higher numbers of patients with high-deductible health insurance plans, increasing patients' financial burden.

Also, insurance companies have increasingly adopted narrow networks to maximize revenue, pushing more physicians out of network.

With all that said, finding a solution is not easy. We need to focus on how we move the patient out of the middle of the financial vice and develop a solution that levels the playing field between payors and providers.

Our Commitment

Finding a fair and balanced solution to address these developments will not be easy. Payors, providers and legislators need to focus on solutions that protect patients from undue financial risks and provide more transparency for all constituencies. One critical change that has to happen is that payors must be required to follow the same generally accepted guidelines for physician reimbursement that providers follow. Payors must also be required to establish transparent guidelines for physician reimbursement and compensate providers consistent with benchmark payment standards established by objective third-party databases.

We also believe payor-driven narrow networks and other exclusive contracting strategies implemented by payors that force providers out of network, thereby limiting patient's choice of providers and access to care, place undue hardships on patients and providers. If a hospital is in-network with a payor, that payor should be required to contract with the physicians performing services in the hospital emergency department at rates that are reasonably acceptable to the providers. We cannot let payors shift their responsibility to pay fair compensation for services provided to their insureds to hospitals, by forcing them to subsidize the emergency physicians to ensure emergency department coverage, and physicians, by forcing them to provide services on an out-of-network basis.

The Cooper Working Paper Review:

The payor-funded Cooper working paper and subsequent press coverage upon which your letter appears to be based have misled the public and our patients about many aspects of the healthcare services industry and, specifically, EmCare's operations. The Cooper working paper is not a research study, the paper was not subject to peer review, the data that allegedly supports the assertions in the paper has not been published (therefore it is not possible to review the data and challenge those assertions), and the paper was intended to generate discussion about these issues, not to set forth definitive findings. We disagree with the methodology and conclusions of the Cooper working paper on many fronts.

In general, it is important to point out:

- The authors make grossly inaccurate conclusions based on a significantly narrow sample size of only 16 hospitals, eight of which are part of the same health system and share identical fee schedules and managed care profiles, as well as similar levels of acuity. A sample size that is too small and not representative of the profession reduces the credibility of the paper, increases the margin of error, and makes it impossible to draw statistically valid conclusions from the paper.

- The data in the paper is inaccurate, including the authors claim that hospitals that contract with EmCare have an average out-of-network billing rate of 62%. Hospitals that contract with EmCare have an average out-of-network billing rate of 21%, which is consistent with profession-wide national averages. The inaccuracy is the result of either faulty data or the statistically invalid sample used for the paper.

Our internal experts reviewed the study and identified several points that may warrant further review and clarification.

3.1 Data

It is not clear if the data source is representative of the area of the contracts. The data excludes many observations and facilities, which could be skewing the results. Specifically, of the 16 hospitals, 8 are from 1 system—thus 50% of the sample will share identical fee schedules, managed care profiles and acuity similarities—a considerably skewed sample structure.

3.2 Identifying Where EmCare and Team Health Have Contracts

We are not able to verify the quality or accuracy of data identifying EmCare contracted facilities (some facilities may have terminated or initiated their contract with EmCare during the evaluated period).

3.4 Descriptive Statistics on Out-of-Network Billing

They calculated patient's potential balance billing as the difference between EmCare's charges vs. the in-network payments. The industry-accepted calculation is the charge, less the insurance payment, less the patient co-pay, less the patient co-insurance, less the patient deductible. These charges are calculated and sent by the insurance company, we are assuming they are using the "Greatest of Three", and the decision on what allowable to be used is dictated by state statute or the payor's preference (not specified).

The study is using an in-network rate that does not address the environment in which many hospitals and physician groups are at a disadvantage in negotiating in-network contracts because they lack critical mass bargaining with the insurance companies.

We can dispute the 266% of Medicare rate is inadequate as a comparison point. Medicare rates have not increased in years. To use this as a standard would mean that providers would not have a mechanism to cover rising costs. Using Medicare as a benchmark for reasonable reimbursement has been totally discredited due to these shortfalls, and other policy issues well beyond the scope of this review.

3.5 Generalizability of our Data

Different insurers target different markets. Without identifying the insurer, it is impossible to determine the accuracy of the study. Data is extremely limited; it is only from one insurer and from a limited number of sites of care. Therefore, it does not accurately reflect EmCare's interactions with that single insurer or others. The data is very general, and the analyzer clearly states that "… **it constitutes an interesting sample to study regardless of generalizability.**" We agree. It is so general that it is impossible to draw statistically valid conclusions.

4.2 Incentives Facing the Insurer in Forming a Network

Quality access for the insurer's membership is noticeably absent in the study. We dispute that usual & customary (U&C) payments are typically set at the average physician charge in a market.

4.3 Incentives Facing the Hospital

The premise is that in order to maintain market reputation, hospitals would have to subsidize the contracted physicians to not balance bill. However, it does not state that hospitals determine a competitive market rate to avoid balance bill. We dispute that "a hospital does not benefit directly from physicians engaging in out-of-network billing" (page 19). Hospitals do benefit directly when higher out-of-network insurance payments rather than hospital subsidies to the emergency physicians, enable the hospital to recruit, retain, and expand high-quality, board certified emergency physicians.

The fact that the study identified 16 EmCare-staffed hospitals during a five-year period argues that:

- The hospital's chief quality measure of patient satisfaction was met, if not increasing.
- The hospital's financial viability and stability had been secured, and was being assured by contract renewals year-after-year.
- The hospital valued the continuity of high quality clinical care from year-to-year as evidenced by the contract continuations.

5.1 Lasso and Within HRR Variation in Hospital's Out-of-Network Billing Rates

EmCare's (alleged) increase of out-of-network rates by 24% does not reference what is gained — gained revenue for recruiting and retaining board certified and highly qualified clinicians who may not otherwise be available, increased staffing to shorten wait times, higher patient satisfaction feedback and scores and better clinical outcomes.

5.2 Within HRR Variation in Payment Rates Out-of-Network Billing

The study's reference to EmCare's physician payments being 36% higher than hospitals that are not outsourcing their E.D.'s, fails to address the benefits of the hospital and their patients — lowered hospital subsidies (often by millions of dollars), stable and adequate provider staffing levels, shorter patient wait times and higher patient satisfaction scores. To cite a higher revenue stream without referencing its positive benefits for the healthcare system is irresponsible.

6.2 Identifying the Impact of EmCare Entering a Hospital

The quoted 23% increase in hospital admission rates can be impacted by multiple factors, including the macro-environment implementation of the Affordable Care Act, which began during the starting period of the study. One primary driver in EmCare's services and operations is physician education and documentation — provider training to record what is clinically done to diagnosis and treat the patients. Poor documentation is often a significant deficiency in hospitals where EmCare begins staffing the E.D. An increase in the prior statistics is to be expected.

Admission rates for EmCare and Team Health are similar. The study excludes discussion of readmission rates either before or after EmCare contracts with the hospital. The study focuses on EmCare's percentage increase for admissions and usage of CPT 99285 but ignores the actual rates between EmCare and Team Health.

7.4 Crafting More Effective Policy to Address Out-of-Network Billing

After paying high premiums, patients still have high deductibles and copays even when in network. Payors have designed and sold an increasing number of high deductible health plans (HDHPs) to employers, **without explaining that there will be numerous surprise insurance gaps in coverage.** This is the number one surprise to be avoided in healthcare coverage—understanding what coverage has—and has not—been purchased by the patient.