The State of Emergency Care in California

“Currently, Emergency Physicians Medical Group staffs 14 Emergency Departments and hospital-affiliated urgent care facilities in California. Recently, we terminated our physician staffing contracts with three hospitals for various reasons, the most important one being the inability to fiscally staff emergency departments with board qualified physicians able to meet the demands of these counties.

All California counties have uncompensated care that emergency physician groups must write off on a daily basis. Many counties depend on emergency departments to care for their population because outpatient clinics do not exist or are unable to provide for the uninsured or indigent populations that contribute to the majority of uncompensated emergency care.

We are evaluating other sites in California and the feasibility of continuing services to these areas.”

Patrice Palmaer, EPMG, 1/3/05
The emergency care safety net in CA is in trouble…..

“I came on duty this morning with 49 patients waiting to be admitted, 3 on ventilators. Many beds closed due to nursing shortage.

I am hearing of a hospital in LA that is holding uninsured patients in the ED for days at a time, even when there are empty beds in their hospital. ED docs are obviously upset but the hosp admin states they are breaking no rules.

I don't even know where to begin to comment”.

Maureen McCollough, MD
New Challenges for Emergency Physicians in California

- 60 ERs closed in the last decade, 9 in the last year
- Inpatient bed shortages
- Admitted patients warehoused in ED for hours, even days
- Increasing numbers of uninsured and underinsured patients
- Fewer primary care providers taking new patients
- ED services increasingly broader and more complex
- Demands for higher patient satisfaction scores
- Nursing shortage puts greater demands on ED physicians
- Managed care expectations for patients to be treated, stabilized and discharged rather than admitted
- ED back-up panels shrinking
- More transfers and ambulance diversions
Emergency Medicine vs. Other Specialties

- Divergence is more pronounced in CA with larger Managed Care penetration
- Half of increase in ER physician income in CA related to closure of 45 ERs
- ER physicians account for less than 3% of all professional services fees
# Health Plans Profit as ERs Fail

In the last 3 years:

**Health Plan Profits increase by 182%**

**17 Emergency Departments Close**

<table>
<thead>
<tr>
<th>Insurer</th>
<th>Profits 2003</th>
<th>Change since 2000</th>
<th>Profit Margin increase</th>
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<td>Aetna</td>
<td>$933.8M</td>
<td>635%</td>
<td>996%</td>
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<tr>
<td>Amerigroup</td>
<td>$67.2M</td>
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<td>985%</td>
<td>1344%</td>
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<tr>
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<td>79%</td>
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<tr>
<td>Cigna</td>
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<td>-30%</td>
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<td>Centene</td>
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<td>33%</td>
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<tr>
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<tr>
<td>Molina Healthcare</td>
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<td>18%</td>
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<tr>
<td>Oxford Health Plans</td>
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<td>Pacificare</td>
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<tr>
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<tr>
<td>WellPoint</td>
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<td>173%</td>
<td>24%</td>
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</table>

*Source: CBS Marketwatch*
Factors that Affect Emergency Physician Charges

Charge per unit of physician work

less → more

- False Claims Act
- Unbundling of codes
- Upcoding
- Charge creep

Mandatory Coding Compliance Programs

Hospital must approve ER group fee schedule
Factors that Affect Emergency Physician Reimbursement

S collected per unit of physician work

less → more

- Dobberteen opinion
- Plans advice to patients not to pay
- Claim and coding denials
- Bundling of codes
- Down-coding
- DMHC failure to regulate IPAs
- Health Plan – CAPG advocacy $$$
- Coercive contracting
- Plan delegation of payment
- Abuse of EMTALA obligation to treat
- Silent PPO discount leasing
- Plans escape AB 1455 under DOI

→ Successful appeal of underpaid claim
→ Patient pressure on Plans to pay
→ DMIIC action against HealthNet
→ CAL/ACEP – CMA advocacy $s
→ Legislative support for emergency care
→ Prospect vs St John decision on balance billing
→ AB 1455 and Gould Criteria
→ Right to balance bill
CEP Contracts with IPAs / MGs

Proprietary data
CEP Global Contracts with Health Plans

Proprietary data
Why ER Groups Contract with Plans and IPAs

- Coercion from hospitals, sometimes bordering on illegal kickback scheme
- Fair-value partnership* with hospital and local IPA to increase patient volume
  * Hospital-ER contract requires negotiation for ‘fair market value’ of services with hospital’s payer network
- Some Plans and IPAs offer reasonable rates to ER groups (value recognition)
- Contracting may reduce claims disputes
- Pressure from colleagues on medical staff networked with IPA
- Fewer requests for copies of medical record with claim
- Eliminates hassles of balance billing
- Improves reputation of ER group as a willing partner with hospitals and medical community
Coercive Contracting

Suggestions by Cathy Kay, California Society of Healthcare Attorneys annual meeting, Mar 20, 2005, for hospital staffing contracts with hospital based providers:

a. Provider must agree to discount services comparable (or equal) to hospital’s discount to networked payer
b. Provider must contract with all payors contracted with hospital
c. Provider must consider modifying its rates to facilitate hospital’s ability to contract with payor

or face the consequences:
1. Hospital may terminate agreement with provider
2. Hospital may revoke provider’s medical staff privileges without the due process required in medical staff bylaws
Why ER Groups Don’t Contract with Plans and IPAs

- No interest from Hospital in participating with IPA or Plan
- No increase in patient referrals anticipated
- IPA or Plan expects unreasonable discount or meet ‘fair market value’ requirement
- IPA or Plan has a history of poor performance, poor payment, or likely financial insolvency
- Failure of previous contract to reduce claims disputes
- IPA has poor reputation with colleagues on medical staff
- Plan or IPA suffers from management incompetence or worse
- ER group can’t afford to deeply discount services for insured payers: too many uninsured patients
- Silent PPO arrangements
CEP % of A/R > 120 days by Payer Category

Proprietary data
CEP AB 1455 Claim Disputes by Insurance Carrier
Mar-Dec, 2004  pg 1 of 23

<table>
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<tr>
<th>Ins Name</th>
<th># Disputes</th>
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<th># Unpaid</th>
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<th>Total # Paid Following PDR</th>
<th>% of Disputes with Paid Following Dispute</th>
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<tr>
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<td>14</td>
<td>3,196</td>
<td>$1,872.15</td>
<td>1,324</td>
<td>4,520</td>
<td>$1,872.15</td>
<td>31%</td>
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Proprietary data
## CEP AB 1455 Claims Disputes Mar - Dec, 2004 - Summary

<table>
<thead>
<tr>
<th></th>
<th>Paid</th>
<th>Unpaid</th>
<th>Total # Visits</th>
<th>Total $ Paid Following PDR</th>
<th>% Of Disputes w/ Pmts Following Dispute</th>
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<td># Visits</td>
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<td>$ Paid Following PDR</td>
<td>$3,931,303</td>
<td>$0</td>
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<td></td>
</tr>
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</table>


Reasons for Disputing Claim by Pmts Received
% of Disputed Claims Paid by Reason for Dispute

- Denied as "non-emergent" or "no authorization"
- Commercial codes denied as unbundled or inclusive
- Non-contr senior- Not paid at Medicare FFS rate
- Contracted - reduced or no pmt
- All other
- No clear reason for denial or adjust.
- Discounted - no contract identified
- Commercial -No resp to claim
- non-contr MCMC reduced or no pmt
- Claims not properly forwarded
- Denied for untimely filing
- Denied as filed late despite "good cause"
- EKG's and/or X-Ray's denied as included in E+M
- Non-Contracted - reduced pmt
- Denied - patient was seen twice on same date
CEP Disputed Claims by Insurance Class
Mar-Dec, 2004

Percent of Disputes with Some Payment

- Other
- Medicare HMO Non-Cont
- Medi-Cal Mgd Care
- Commercial Contracted
- Comm'l Non-Contracted

0% 10% 20% 30% 40% 50% 60%
Percent of Claims Disputed by Payer Category

- Comm'l Non-Contracted: 35%
- Contracted: 5%
- MediCal Mgd Care: 10%
- Medicare HMO Non-Contract: 15%
- Average: 20%
Why Health Plans MUST Pay Their Fair Share to Support the Emergency Care Safety Net

- Emergency care is an essential service - without it managed care could not exist
- Medi-Cal provider payment lowest in US
- Growing population of under and uninsured
- Hospitals closing their ERs and/or down-grading services
- On-call specialists abandoning ER backup panels
- Increasing problem recruiting and retaining qualified Emergency Physicians in CA
- Health Plan capitation rates lowest in US
- Delegated model and coercive contracting squeezing EMTALA obligated provider reimbursement - most plans have never paid their fair share
Possible Solutions

- Enforcement of AB 1455 for all Plans and delegated payers
- AB 1455 for Department of Insurance regulated Plans
- Use Gould criteria to address outlier charges, not set fees
- Outlaw Silent PPOs
- De-delegate (carve out) emergency care services
- Enforce anti-kickback statutes to reduce coercive contracting
- Encourage three-way negotiations: hospitals, providers, and payers
- Require networks to contract with emergency care providers
- Preclude delegation for non-contracted emergency care services
- If provider is contracted with the Plan, and not the delegated payer, the Plan should pay the claim
The Bottom Line

• ER physicians are on the front line - we are the safety net for the uninsured and for managed care
• 9 ER closures in last year - 60 in last 10 yrs
• Health Plan profits have increased by 182% from 2000 to 2003
• Contracting must be a quid-pro-quo arrangement, not indentured servitude
• Profiteering at the expense of ethical providers harms patients and consumers
• The DMHC must counter-balance the EMTALA obligation with regulatory enforcement to ensure a fair marketplace for emergency care providers