EMP

Emergency Medicine Physicians

Testimony to the Committee on Human Services regarding House Bill No. 7299:
An Act Concerning Reimbursement Rates to Physicians Who Provide Emergency Room Services to Medicaid Recipients.

March 8, 2007:

My name is Michael Frank. Although I am an attorney serving as General Counsel for Emergency Medicine Physicians (EMP), a network of emergency physician groups located in the Midwest and Northeast, including EMP of Fairfield County, a group organized to practice at The Stamford Hospital in Stamford, I am also a physician who has been practicing emergency medicine for the past 27 years and it is primarily as a physician member of EMP that I am testifying here today in **support of House Bill No. 7299 entitled *"An Act Concerning Reimbursement Rates to Physicians Who Provide Emergency Room Services to Medicaid Recipients."*** I would like to note for the record that although I have lived in Ohio since 1970, I was born and raised in New York, and received my undergraduate education at Yale. Since then, I have always considered this to be my old stomping grounds, and I am delighted to have the opportunity to return here to share my thoughts with you.

Emergency medicine is the country's newest medical specialty. When we discuss the evolution of that specialty, forty years ago is ancient history, predating specialty training in emergency medicine, board certification in emergency medicine, or even the notion that emergency medicine might really be a specialty. Forty years ago, emergency departments were staffed by interns and residents in training, or physicians starting out in practice who needed some income while they were building a private practice outside the hospital. Any physician who practiced in the emergency room did so as an employee of the hospital. It wasn't until the 1970's that emergency medicine began to evolve, as a specialized medical field, and organizationally as a new business model. The first emergency medicine residencies were established in the 1970's and the American Board of Emergency Medicine was officially recognized by the American Board of Medical Specialties in 1979. Whereas emergency medicine practice had previously been considered merely a waystation for a physician on his or her way to private practice in some other specialty, the country now saw growing numbers of physicians, like myself, who elected to devote their careers to emergency medicine. The evolution of the medical specialty also brought with it an evolution of the predominant business model. Instead of hiring physicians as employees, hospitals began contracting with groups of career emergency physicians who brought new expertise to the care which the hospitals could offer to patients coming to the emergency department.

EMP embraces that model. In 2002, Emergency Medicine Physicians of Fairfield County was established, entering into an arrangement with The Stamford Hospital to provide emergency physician staffing at the Stamford Hospital Emergency Department. Under this arrangement, the physicians in the group work in the hospital's emergency department, providing medical care to all patients, their sole compensation being derived

4535 Dressler Road NW ▪ Canton, Ohio 44718
(330) 493-4443 ▪ Fax (330) 493-8677

from the fees that are collected by our own billing and collection activities. The hospital does not pay for our physicians' services; our compensation comes from patients and/or their insurers.

It is fair to say that although the hospital employee model of emergency medicine is far from extinct, the predominant model of emergency physician staffing in the United States is now a private practice model in which the hospital contracts with a group of emergency physicians. For reasons which someone wiser than I might be able to explain, the employee model has remained much more prevalent in the Northeastern United States than in most other areas of the country. Which brings me to reason for this bill.

Under the current DSS Medical Services Policies (specifically DSS Medical Services Policy 150.1E.IIf, the "ED Services Exception", a copy of which is attached as Exhibit A to my testimony), when my emergency physician colleagues in Connecticut treat a Medicaid patient whose condition is serious enough to require admission to the hospital, the Connecticut Medical Assistance Program will pay the hospital for the service provided by the hospital, but will not pay the emergency physician who has actually treated the patient. The ED Services Exception was created under the assumption, perhaps understandable and acceptable years ago, that the physicians treating Medicaid patients in the emergency room were all hospital employees, paid by the hospital, which in turn was being paid a fee which encompassed all of the costs the hospital incurred in providing emergency room service, including the payments the hospital made to the emergency physicians. In other words, to use the current terminology of medical billing, payments for the technical and professional components of the service provided were one and the same. The inequity of this policy derives from the fact that these assumptions are no longer valid or applicable to a growing number of emergency physician groups. Moreover, the assumption that the hospital is actually collecting the "professional component" is also faulty, since the hospital does not compensate our physicians for these services, and does not carry any such amounts on the cost reports which determine the hospital's payments.

The physicians of EMP of Fairfield County do not receive any payments from the hospital. We are paid only from the fees that we collect from patients and/or their insurers. We understand that if we don't do a good job, if we don't provide proper care, if we don't meet the needs of our patients, we won't get paid. What our physicians don't understand, what I don't understand, is how DSS can justify not paying us for the service we are providing.

Adding insult to injury, DSS payment policies differ dramatically with respect to the services provided by other "hospital-based physicians" (which includes radiologists, pathologists and anesthesiologists), who function under the same private practice group model, contracting with the hospital, as we do. For example, if an EMP physicians treats a Medicaid patient who has a fever, chest pain, shaking chills and a productive cough; orders a chest x-ray which shows pneumonia; then treats the patient with antibiotics and arranges for the patient to be admitted to the hospital as an inpatient, DSS will pay the

EMP physician who treated the patient nothing, but will nevertheless pay a professional fee to the radiologist who interpreted the x-ray. The irony is that under current DSS policy and practice, DSS will pay the radiologist who may never actually see the patient, while the emergency physician who actually sees and treats the patient gets nothing. Privately employed pathologists, anesthesiologists and other physicians who provide care to Medical Assistance Program are treated in a fashion similar to radiologists. Only the emergency medicine physician is denied reimbursement for professional services in this situation.

Oddly enough, the DSS policy and application of the ED Services Exception as described is inconsistent with Medicaid Service Policy 150.1I.II.d.11. That policy provision, which is attached to my testimony at Exhibit B, states that "[t]he per diem reimbursement rate is the all inclusive payment in full for all services provided to [Medical Assistance Program] recipients when they are inpatients. This includes hospital based physician and dental fees. The exception is physicians who are not providing services as salaried staff by the hospital. These services may be billed by the physician or dentist to the Medicaid program." (emphasis added) As I have previously mentioned, the claims being denied are for services rendered while the Medicaid recipient is still an outpatient of the hospital and employees of private emergency physician groups are not salaried staff of the hospital. Accordingly, the claims these groups submit should be eligible for payment.

Lest there be any question as to the legitimacy and acceptability of the private practice model I have described, I have also attached to my testimony at Exhibit C, a copy of Provider Bulletin 2004-76, in which DSS specifically recognizes that hospitals contracting with private physicians or physician groups to provide emergency department coverage constitute an acceptable arrangement for Medicaid billing purposes. Presently, at least four of Connecticut's 31 acute care hospitals staff their emergency departments in this manner and more are expected to follow.

Every member of our group is board-certified in emergency medicine. As visits to emergency rooms by the elderly, the uninsured and other segments of the population continue to increase, the special training of our physicians helps provide emergency patients with care that is safer and of higher quality than might otherwise be possible. Professional fees continue to be ratcheted down by commercial payors, and although emergency physicians treat all patients without regard to financial status, the growing numbers of uninsured patients who seek care in the emergency department means that reimbursement of emergency physicians will continue to contract. We can therefore ill afford to provide professional services to Medicaid patient under an obsolete institutionalized policy which provides us with no compensation at all. Even if the impact of our physicians' services were negligible, fundamental fairness would require revision of the current policy. However, when one considers that fact that the emergency medicine that our physicians provide can often mean the difference between life and death for the

patient, there is simply no justifiable reason why the Connecticut Medical Assistance Program should not compensate us fairly for the vital professional services we provide.

In summary, our emergency physicians and other similarly situated emergency medicine physician groups throughout Connecticut would benefit from the proposed amendment to Section 17b-239 of the Connecticut General Statutes to require that the rate paid by the Commissioner of DSS to any physician who provides professional services to a Medicaid beneficiary in the emergency room of a hospital be separate and distinct from the rate provided to such hospital for the provision of services. I think we all can agree that both hospital emergency departments and the physicians who staff them provide very important services to the citizens of this state who rely on the Medical Assistance Program as their health care safety net. It is only fair then that DSS compensate both parties for the services they provide. House Bill 7299 will help ensure that this remains the case without exception.