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COMMITTEE ON HUMAN SERVICES
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THE CONNECTICUT COLLEGE OF EMERGENCY PHYSICIANS SUPPORTS HB-5329,
"AN ACT CONCERNING REIMBURSEMENT RATES TO PHYSICIANS WHO
PROVIDE EMERGENCY ROOM SERVICES TO MEDICAID RECIPIENTS."

Good afternoon Representative Walker, Senator Doyle, and Committee members. Thank you for the opportunity to present my testimony on HB-5329. I am the President of the Connecticut College of Emergency Physicians, the organization which represents nearly 500 Board-Certified specialists who have devoted their careers to being on the front line of emergency medical care.

Emergency Departments in the State of Connecticut provide around the clock medical services to our citizens. We are society's safety net for a fragile and fragmented health care system. We care for all patients regardless of the severity of the complaint or the individual insurance status. Provision of these services is labor intensive and quite expensive due to staffing and equipment requirements needed to be ready for emergency patients 24/7/365. Emergency Departments function as both the front line in our struggle to provide health care to a diverse society as well as the final safety net when all options are exhausted. People assume emergency care will always be available when needed, but unless society starts to treat and fund emergency departments as an essential resource like the fire, police, and EMS departments then one day timely care may be unavailable. This is already occurring as the demand for emergency department visits is increasing while available emergency department beds are decreasing.

Federal law (EMTALA) requires that any patient presenting to the Emergency Department with a medical complaint be given a screening exam, stabilizing treatment, and appropriate follow-up or hospital admission as needed. Due to the large number of uninsured and underinsured patients, the financial strain of providing quality emergency care for all is becoming increasingly difficult. An area of particular concern is *post hoc* determination by both government and private insurers that the condition which was treated in the emergency department was "not an emergency" resulting in a reduction or outright denial of payment. The *prudent layperson* standard, by which the initial symptoms and not the final diagnosis determine the basis for an emergency department evaluation, has been in effect for over a decade. Unfortunately, this principle is indirectly being challenged by post-hoc analysis.

The manner in which the Department of Social Services administers the Medicaid insurance program creates significant barriers for Connecticut's Emergency Departments to fulfill their mission to provide timely and compassionate emergency care to all patients at all times. Some of these decisions are based on an antiquated system when all emergency physicians were hospital employees. This is no longer the case throughout the country and Connecticut has begun to transition to this more accepted model of non-

hospital employed emergency physicians. Other decisions are based on retrospective reviews and administrative maneuvers which result in under-funding emergency care and thus jeopardizing access to quality emergency care and patient safety.

Medicaid inappropriately bundles payment for professional and facility fees for emergency services. Emergency physicians should be treated like all other hospital based physicians, which include the specialties of anesthesiology, radiology, surgery, and pathology. Just like with services provided by a hospital and those specialists the resultant bill contains both a facility fee and a professional physician component. Currently, the emergency physician's professional component for admitted Medicaid patients is bundled in to the hospital's per diem rate. All emergency physicians should be recognized for the outstanding care provided to Medicaid patients. Regardless of the employment structure, DSS should pay for this specialized and essential service. Emergency physicians should not be singled out and required to negotiate with hospitals for fair payment of services provided. Medicaid fees are already below cost. To then deny these nominal fees would force less coverage and result in longer waiting times and decreased access to quality emergency care.

Medicaid reviewers conduct audits of sample charts which frequently result in down-coding of the level of service. The resulting amount of money which is presumed to have been overcharged is then extrapolated to all of the charts with the same diagnosis resulting in a large sum which is owed to Medicaid. On appeal, these charts are reviewed by nurse-bureaucrats who invariably agree with the Medicaid auditors. We are of the opinion that the appeal process is flawed in that the reviewers are not qualified to judge the many factors which enter into the original coding decisions. We feel review by at least one qualified, practicing emergency physician should be a mandatory part of the appeal process, particularly when the findings of the audit are then extrapolated to other charts which have not been audited.

Here is a scenario of a Medicaid patient who presents to the ED and some of the thought processes and policies which affect the ultimate management. A 50 year old mother of two has a low-paying job which does not provide health benefits and thus she is on Medicaid. The only provider which accepts Medicaid is a federally qualified Health clinic but she has trouble making a visit because of the limited hours and the fact she can lose her job if she calls out from work. She neglects any preventative care and ignores symptoms until they are more severe and comes to the ED late at night when only the emergency department is open with chest pain. After a thorough evaluation in the Emergency department, when no clinician even knew or asked her insurance status it is determined she might have a 15% chance of this being cardiac induced chest pain. Because timely follow up care at the FQHC is questionable and because missed heart attack is the biggest liability payout for emergency physicians, she is admitted to the hospital. Fortunately, after further testing done over the next 24 hours which includes a stress test and lab work, the pain was not from her heart. However, three months later the emergency physician is not paid because the professional fee is bundled into the hospital. Since it was not her heart, retrospectively DSS' review determines the tests could have been done as an outpatient and requests further funds back from the hospital. Since, this

case represented 20% of the charts reviewed; DSS demands are extrapolated to all Medicaid patients. The hospital which is already in financial trouble decreases services in order to stay financially viable and access and safety are further compromised.

In summary, we support HB 5329 because it prohibits the practice of DSS bundling the emergency physician fee with the hospital payment. Although the beginning of subsection (e) is existing statute, we are concerned about the retrospective review language highlighted in the bill which contradicts the spirit of prudent layperson laws. Although Emergency Medicine is a relatively new medical specialty, only about 40 years, it is highly competitive field attracting the best and brightest medical students. Emergency physicians expect and deserve the rights and privileges afforded to all physicians. Furthermore, emergency patients rely on our presence 24 hours per day, seven days a week. To allow this inequity to continue segregates emergency physicians as second class physicians and endangers access to quality emergency care for all the patients we serve.