TESTIMONY OF GREGORY L. SHANGOLD, MD, FACEP
PAST-PRESIDENT AND CURRENT LEGISLATIVE CHAIR,
CONNECTICUT COLLEGE OF EMERGENCY PHYSICIANS
COMMITTEE ON HUMAN SERVICES
MARCH 1, 2012

THE CONNECTICUT COLLEGE OF EMERGENCY PHYSICIANS SUPPORTS SB-236,
"AN ACT CONCERNING REIMBURSEMENT OF EMERGENCY ROOM PHYSICIANS FOR TREATMENT OF MEDICAID RECEIPIENTS."

Good afternoon Representative Tercyak, Senator Musto, and Committee members. Thank you for the opportunity to present my testimony on SB-236. I am the Past-President and current legislative chair 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.

Medicaid, and specifically Medicaid recipients, have become under increased scrutiny over the past years as the nation has struggled with reforming the healthcare system. Many experts predict current Medicaid spending to be unsustainable and have looked at it as a place to cut spending, however, Medicaid growth is predicted as uninsured people will be transitioned to Medicaid. Clinical resources available to Medicaid beneficiaries are already severely limited. Adding more people at less cost will exacerbate this inequity. Emergency Departments are bracing for an influx of these new recipients who will have no where else to turn to other than emergency departments. Many of these emergency patients will require admission because of the lack of management of chronic conditions. Emergency physicians who will care for these patients should be paid, even at the nominal current rate.

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 invoice 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 below-cost fees would force less coverage and result in longer waiting times and decreased access to quality emergency care.

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 loose 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 SB 236 because it prohibits the practice of DSS bundling the emergency physician fee with the hospital payment. 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.