American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

April 28, 2011

The Honorable Fred Upton
Chairman
Committee on Energy & Commerce
2125 Rayburn House Office Building
US House of Representatives
Washington, DC 20515

Dear Chairman Upton:

On behalf of the American College of Emergency Physicians (ACEP), I am pleased to respond to your letter of March 28, co-signed by Representatives Waxman, Barton, Dingell, Pitts, Pallone and Burgess, seeking specific ideas and proposals on how to reform the physician payment system. ACEP is a national emergency medical specialty society with more than 29,000 members. ACEP is committed to improving the quality of emergency care through continuing education, research, and public education. We appreciate the opportunity to provide comments to you on this important initiative.

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For nearly 10 years, the SGR formula and resulting fee schedule reductions have negatively affected emergency physicians disproportionately. While physicians in other types of practice can limit their financial losses in ways considerably more subtle than dropping participation in the Medicare program, emergency physicians continue to see everyone who comes to the emergency department, regardless of their ability to pay. As you know, the unfunded EMTALA mandate has now been in place for nearly 25 years, creating such financial strains on hospitals in certain areas that ERs and sometimes entire hospitals (e.g. Los Angeles, New York City) have closed. This has occurred several hundred times in the past several years, in spite of hospitals receiving positive annual update payments and disproportionate share payments to compensate for low income and uninsured patients. For emergency physicians, there is no offset payment for uncompensated care. In a recent study that CMS used for the 2009 Medicare Physician Fee Schedule, uncompensated care for emergency physicians was estimated at $139,000 per physician per year. As part of its consideration of changes to the funding formula for physician payments, we urge Congress to fund the EMTALA mandate.

We believe that Congress must take into consideration the unique form of care provided by emergency physicians. Emergency physicians provide care 24 hours per day, 7 days a week. They are medical specialists who are prepared to care for every type of medical emergency—and do so in a high risk environment--often with little or no information about their patients. Emergency physicians treat patients of all ages and incomes. According to the American Medical Association, emergency physicians provide four to 10 times as much charity care as any other physician specialist. For these reasons, we do not believe any new payment methodologies should penalize emergency physicians who may readmit sick patients.

Unlike other medical providers, emergency physicians never turn patients away. The health reform law (PPACA) will greatly expand insurance coverage starting in 2014, and many of the provisions in the law are designed to shift patients to primary care physicians who will coordinate their care. This is a laudable goal, but current demand for primary care already outstrips the supply. The volume of emergency visits is showing no signs of

diminishing. Even in states like Massachusetts where 97 percent of the population has coverage, ER visits continue to grow. According to the Centers for Disease Control and Prevention (CDC), emergency visits in 2008 grew to 124 million, the highest level ever reported. In addition, we believe that when the estimated 16 million individuals are added to Medicaid, the volume of ER visits will sharply increase as the supply and willingness of physicians in the community to add more low paying Medicaid patients to their practices falls short. A recent Center for Disease Control report shows that the percentage of emergency patients seeking care for nonurgent medical conditions dropped to less than 8 percent (in 2007) and has been dropping since 2005 when it was 13.9 percent. The CDC defines "nonurgent" as "needing care in 2-24 hours." With the anticipated increase in demand for medical services from highly trained physicians and other professionals, it is imperative that the Sustainable Growth Rate (SGR) formula be repealed. The formula is fundamentally flawed in that it fails to take into consideration the cost of caring for Medicare beneficiaries, a cost that has outstripped the gross domestic product (GDP). Additionally, the measure used to determine target spending is based on 1997 projections and fails to recognize, as previously discussed, the level of uncompensated care many physicians, emergency physicians in particular, bear in the current system.

On more than 12 separate occasions, Congress has acted to prevent dramatic cuts from being imposed under the SGR formula. But those interventions, added to one another, have cost nearly $300 billion without addressing the underlying problem. With a projected reduction of 29.5 percent due in January, 2012, there can be no alternative but to repeal the SGR.

We encourage the Committee and Congress to carefully assess the many models currently being demonstrated or piloted in Medicare and in the private sector. As well, a thorough analysis of the many quality initiatives now being implemented, and those called for in the Affordable Care Act, should reveal the promise of savings from higher quality care. A period of stability in physician payments is critical to those savings and the longevity of the Medicare program.

Congress can take demonstrable steps to help reduce health care costs. According to the PricewaterhouseCoopers Health Research Institute, the top three areas of waste in the health care system are (1) defensive medicine (estimated at $210 billion annually), (2) inefficient claims processing (up to $210 billion annually), and (3) care spent on preventable conditions related to obesity ($200 billion annually). Clearly, medical liability reform and the establishment of health courts would help cut costs by reducing the amount of defensive medicine practiced by emergency physicians and other physicians treating patients in emergency departments.

As the Committee addresses these issues, we encourage the Committee to recognize the value of care provided in emergency departments and to avoid misconceptions about the "cost of unnecessary care" provided in "inefficient emergency rooms." According to U.S. government statistics, emergency care represents less than 2 percent (1.9 percent) of the $2.4 trillion spent on health care.

Emergency physicians and their departments are essential to the nation's health care delivery system. They are truly America's health care safety net. A stable and fair reimbursement system, combined with reasoned system reforms, can help us meet the rising demand for care just as new innovations and solutions unfold. Health information technology (HIT) is a critical piece of the transition to coordinated care in communities.

Care coordination between primary care physicians, hospitals and emergency departments can only be effective if a meaningful electronic health record adopted by all providers is implemented in the near term.

We look forward to working with the Committee on Energy and Commerce as it addresses the flawed SGR formula.

Sincerely,

Sandra Schneider, MD, FACEP
President

CC: Rep. Henry Waxman (CA)
Rep. Joe Barton (TX)
Rep. John Dingell (MI)
Rep. Joseph Pitts (PA)
Rep. Frank Pallone, Jr. (NJ)
Rep. Michael Burgess (TX)

House Energy and Commerce Committee Members