Statement of

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Introduction

Mr. Chairman and members of the committee, my name is Angela Gardner, M.D., F.A.C.E.P. I am a practicing emergency physician from Texas where I have treated patients for more than 20 years. I completed my emergency medicine residency and internship at the Texas Tech Regional Academic Health Center in El Paso, Texas. Currently, I serve as an Assistant Professor in the Division of Emergency Medicine, Department of Surgery, at the University of Texas Medical Branch, as well as Vice President of the American College of Emergency Physicians' (ACEP) Board of Directors.

ACEP is the largest specialty organization in emergency medicine, with more than 25,000 members committed to improving the quality of emergency care through continuing education, research, and public education. ACEP has 53 chapters representing each state, as well as Puerto Rico and the District of Columbia, and a Government Services Chapter representing emergency physicians employed by military branches and other government agencies.

Thank you for allowing me to testify today on behalf of ACEP to discuss the severe impact on vulnerable populations and safety net hospitals if the Centers for Medicare & Medicaid Services (CMS) is allowed to reduce Medicaid payments to states by approximately $5 billion, as it has proposed to do through the regulatory process. Today, I will share with you several important factors that make the care received in the emergency department unique and how the proposed Medicaid cuts will further erode access to lifesaving emergency medical care for everyone – not just the uninsured – in my home state of Texas, as well as around the country.

Let me begin by expressing our belief that Medicaid is an essential component of the nation's health care safety net. Since the program's inception in 1965, it has improved the health of millions of people who might otherwise have gone without medical care for themselves and their children. Medicaid provides access to health care for more than 50 million Americans and is vital to hospitals and other health providers serving this vulnerable population.

Background of CMS Regulation

On January 18, 2007, CMS published a draft regulation in the *Federal Register* that would alter the criteria of eligible state funds used for the non-federal share of Medicaid. CMS has stated its goal is to improve the fiscal integrity of the Medicaid program and ensure that states are held accountable for sources and amounts of funds used to secure federal matching dollars. However, we take issue with the restrictions in the proposed definitions of the sources of eligible state funds and what is considered an allowable payment to public providers. **There is no question that this proposal will jeopardize the viability of public and other safety net hospitals.**

For a number of years, CMS' Medicaid policy permitted payment to public hospitals that was greater than actual costs in recognition of the burden public hospitals bore for uncompensated care and for the fact that Medicaid payment rates are often below provider costs. In many cases, these policies have been approved by CMS through annual state plan amendments.

Reducing Medicaid payments to states by approximately $5 billion, with no transition period, would further impair an already overtaxed public health system held together by doctors and nurses who are still dedicated to providing the best care for their patients. It is unrealistic to expect that states will be able to fund this shortfall, and we are deeply concerned that states will limit Medicaid eligibility, be forced to reduce benefits, or further reduce provider payments. Any of these options would not only harm access to primary care and specialty medical services for Medicaid beneficiaries, but the result would disproportionately burden America's already strained emergency departments, which will affect everyone's access to emergency care.

In my home state, about 3.7 million Texans (16.2 percent of the state's population) lived at or below the federal poverty level in 2005, and approximately 39 percent of these were children under age 18. Thirty-two percent of all children are enrolled in Medicaid. It is estimated that another 1.3 million children are uninsured, placing Texas 51st (worst) in a state ranking performed by "The Commonwealth Fund." Thirty percent of adults (ages 18 – 64) and 20 percent of children (up to age 17) are uninsured in Texas, also resulting in a 51st ranking among all states. Most telling of all, nearly 20 percent of Texas adults reported that they went without seeing a doctor when needed because they could not afford the care.

Current State of Emergency Care

According to the most recent Centers for Disease Control and Prevention (CDC) report, more than 115 million patient visits were made to emergency departments in 2005, representing a 20 percent increase in patient visits over 10 years. During this same period, the number of emergency departments in this country decreased by nine percent. Medicaid/SCHIP beneficiaries accounted for more than 28 million (24 percent) of emergency department visits in 2005.

Along with the increase in volume and decrease in capacity over the past decade, emergency departments have been faced with numerous other challenges. According to the findings of the Institute of Medicine (IOM) report "Hospital-Based Emergency Care: At the Breaking Point," released in June 2006, emergency departments are overcrowded, surge capacity is diminished or being eliminated altogether, ambulances are diverted to other hospitals, patients admitted to the hospital are waiting longer for placement to inpatient floors, and the shortage of medical specialists is worsening. Simply put, our patients are suffering at an alarming and increasing rate.

It is imperative that policymakers understand the environment and the impediments to care that our patients face on a daily basis – and how payment cuts will contribute to the collapse of our nation's safety net health care system that is barely being held together now. With that knowledge, you will have a better sense of how access to emergency care will be further harmed by the CMS rule. For this reason, I would like to explain in some detail the issues that make emergency departments unique among all health care providers.

EMTALA

First, and foremost, is the federal mandate of the Emergency Medical Treatment and Labor Act (EMTALA) of 1986. The congressional intent of EMTALA, which requires hospitals to provide emergency medical care to everyone who requests it, regardless of their ability to pay or insurance status, was commendable and ACEP has long supported its goals as being consistent with the mission of emergency physicians.

However, having the only universal mandate for providing health care in this country, America's emergency departments have become a portal for providing care to individuals from all walks of life, rich and poor, children and adults, insured and uninsured. There is a popular perception that the United States already has universal health care coverage because the emergency department treats everyone equally, regardless of their ability to pay, and we are open 24 hours a day, seven days a week, 365 days a year.

Medicaid pays most health care providers less than the cost of providing that care. ACEP believes cuts of the magnitude projected under the proposed rule will adversely affect access and the viability of our nation's safety net providers. As Medicaid physician payment continues to lose ground to growing practice costs, fewer physicians will accept Medicaid and even more recipients will end up seeking care in the emergency department.

Emergency physicians believe we have an ethical and moral obligation to provide this care, but we are operating at or over capacity on a daily basis with already limited resources at our disposal. The health care safety net that we provide is at the breaking point. The impact of the CMS rule on emergency department overcrowding, availability of on-call specialists, reimbursement, ambulance diversion and lack of surge capacity, would only reduce our limited resources further with potentially devastating consequences to every community around the country.

Emergency Department Overcrowding

Every day in emergency departments across America, critically ill patients line the halls, waiting hours – sometimes days – to be transferred to inpatient beds. This causes gridlock, which means other patients often wait hours to see physicians, and some leave without being seen or against medical advice. Contributing factors to overcrowding

include reduced hospital resources, which would be further restricted under the CMS rule; a lack of hospital inpatient beds; a growing elderly population and an overall increase in emergency department utilization; and nationwide shortages of nurses, physicians and hospital technical and support staff.

I would also like to dispel the misconception that emergency department overcrowding is caused by patients seeking treatment for non-urgent care. According to the latest CDC emergency department data, less than 14 percent of all emergency department visits are classified as "non-urgent," meaning the patient needed to be treated within 24 hours. **Overall, almost 70 percent of the patients arriving at the emergency department need to be seen within two hours and 15.3 percent of those patients need to be seen within 15 minutes.**

In addition, emergency care is cost efficient, representing less than 5 percent of the nation's $1.5 trillion in health care expenditures. While emergency departments have additional "stand-by" costs because we are available 24 hours a day, the average cost of a non-urgent visit to an emergency department is comparable to a private physician's office visit.

On-Call Shortage

As indicated by the IOM report, another factor that directly affects emergency patient care, which will be made worse by the CMS proposal, is the shortage of on-call specialists due to: fewer practicing emergency and trauma specialists; lack of compensation for providing these services to a high percentage of uninsured and underinsured patients; substantial demands on physicians with busy practices outside the hospital; increased risk of being sued/high insurance premiums and the relaxed EMTALA requirements for on-call panels.

Reimbursement and Uncompensated Care

The patient population can vary dramatically from hospital to hospital, and the differences in payer-mix have a substantial affect on a hospital's financial condition. Of the 115 million emergency department visits in 2005, people with private insurance represented nearly 40 percent, 25 percent were Medicaid or SCHIP enrollees, 17 percent were Medicare beneficiaries and another 17 percent were uninsured. These numbers demonstrate the large volume of care provided in the emergency department to individuals who are underinsured or uninsured.

According to an American Hospital Association (AHA) statement from 2002, 73 percent of hospitals lose money providing emergency care to Medicaid patients while 58 percent lose money for care provided to Medicare patients. Even private insurance plans still frequently deny claims for emergency care because the visit was not deemed an emergency in spite of the "prudent layperson standard" which ACEP has strongly advocated for years.

While emergency physicians stand ready to treat anyone who arrives at their emergency department, uncompensated care can be an extreme burden at hospitals that have a high volume of uninsured patients, which now exceeds 47 million Americans and continues to rise. Hospital emergency departments are the providers of last resort for many people, including undocumented aliens, who have no other access to medical care. As such, emergency departments experience a high-rate of uncompensated care.

Ambulance Diversion

A potentially serious outcome from overcrowded conditions and lack of resources in the emergency department is ambulance diversion. The GAO reported two-thirds of emergency departments diverted ambulances to other hospitals during 2001, with crowding most severe in large population centers where nearly one in 10 hospitals reported being on diversion 20 percent of the time (more than four hours per day). A study released in February 2006 by the National Center for Health Statistics/CDC found that, on average, an ambulance in the United States is diverted from a hospital every minute because of emergency department overcrowding or bed shortages. According to the AHA, nearly half of all hospitals (46 percent) reported time on diversion in 2004, with 68 percent of teaching hospitals and 69 percent of urban hospitals reporting time on diversion.

As you can see from the data provided, this nation's emergency departments are having difficulty meeting the day-to-day demands placed on them. Overcrowded emergency departments lead to diminished patient care and ambulance diversion. We must take steps now to avoid a catastrophic failure of our medical infrastructure and we must take steps now to create capacity, alleviate overcrowding and improve surge capacity in our nation's emergency departments.

Conclusion

Unless Congress acts decisively, the moratorium enacted in May will expire and the nation's public hospitals and emergency departments will sustain a devastating fiscal blow from which recovery may be impossible. Congress has three times this year sent a loud and clear signal to the nations most vulnerable – our children – that providing them with health care is a priority. Let's be equally resolute in this hour of need for the poor individuals and families served by the Medicaid program.