January 16, 2015

The Honorable Fred Upton
Chairman
House Energy and Commerce Committee
2125 RHOB
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
House Energy and Commerce Committee
2322A RHOB
Washington, DC 20515

Dear Chairman Upton and Ranking Member Frank Pallone:

On behalf of the American College of Emergency Physicians (ACEP), our 33,000 members and the more than 136 million patients we treat every year, we want to thank you for this opportunity to discuss graduate medical education (GME) and the unique workforce challenges facing emergency medicine.

The Association of American Medical Colleges (AAMC) estimates that the U.S. will face a shortage of more than 130,000 physicians by 2025, evenly divided between the need for more specialists and primary care physicians. This statistic is particularly troubling for emergency medicine because we not only provide acute, lifesaving care for our patients, but our role has evolved over the past several decades because of the federal "Emergency Medical Treatment and Labor Act" (EMTALA) mandate. The "anti-dumping" intent of EMTALA is consistent with the mission of ACEP and the public trust held by our emergency physician members. However, it does mean that emergency physicians treat a disproportionate number of indigent and uninsured patients who are otherwise unable to access timely health care services.

Any deficiency in the physician workforce, whether in medical specialties or primary care, means our patient load will increase at a time when we are already facing our own shortage of residency trained, board certified emergency physicians. In fact, a 2012 report released by the Centers for Disease Control and Prevention (CDC) found that almost 80 percent of adults who visited the emergency department over a 12-month period did so because of a lack of access to other health care providers. Without enough board-certified emergency physicians in practice, the quality and consistency of emergency care will vary greatly across the country. This is particularly true in rural emergency departments that typically have lower levels of staffing and are much less likely to have emergency medicine specialists on staff. Furthermore, the lack of qualified emergency care personnel in these areas has a disproportionate impact on health care outcomes because of the severity and time-sensitive nature of the illness or injury.

Well-educated and experienced emergency physicians provide the best and most cost-effective emergency health care because the training emergency medicine residents receive is unlike any other medical specialty. Patients often present to the emergency department with signs and symptoms rather than a known disease or disorder. Thus, an emergency physician's approach to patient care begins with the recognition of patterns in the patient's presentation that
point to a specific diagnosis or diagnoses. Pattern recognition is both the hallmark and cornerstone of the clinical practice of emergency medicine, guiding the diagnostic tests and therapeutic interventions during the entire patient encounter. It is this unique training that prepares emergency physicians to properly evaluate and treat any patient requiring expeditious medical, surgical or psychiatric care.

To create more training opportunities for emergency (and other) physicians, Congress should immediately consider raising the cap on the number of residency slots supported by Medicare, which was based on the number of residents a teaching hospital reported nearly 20 years ago in 1996. Two bills considered in the House of Representatives during the 113th Congress (H.R. 1180, the "Resident Physician Shortage Reduction Act," and H.R. 1201, the "Training Tomorrow's Doctors Today Act") would have provided an increase of 3,000 additional slots per year over five years. ACEP supports this modest goal of expanding the program. Even though this would still lead to a significant shortage of physicians in future years, the margin would be smaller than if we remain on the current path. It would also provide additional time to consider and test other mechanisms to support physician training.

Another action Congress should consider is providing an exemption from residency infrastructure costs for rural hospitals. For many rural institutions, teaching hospital accreditation and ongoing administrative costs are prohibitive, which ultimately limits the ability of residents to train in non-urban settings. This is exacerbated for emergency medicine residents because non-hospital settings, including non-teaching facility rural hospitals or other sites that may provide a key component of emergency residency training (i.e., poison control centers, pediatric centers), do not receive reimbursement from CMS because the outside hospital does not incur "all or substantially all" of the training costs (as dictated by GME policy). In this case, neither the primary teaching hospital residency nor the outside hospital receives compensation, thus creating a disincentive to the development of rural emergency medicine rotations and other non-hospital-based training opportunities.

To promote rural rotations for physicians, Congress could require training at more than one site (urban/non-urban) during the course of a physician residency, provided GME rules are appropriately modified to ensure residency programs are not financially penalized. This would create a hub-and-spoke model for physician training that could be further enhanced through the use of telemedicine services originating at the source of the primary residency.

Two other issues should be addressed in order to enhance physician and public oversight of how and where residency training occurs. First, more transparency is needed to understand how federal funding is utilized by teaching hospitals. This will ensure program value for the public investment in GME. Second, a single entity is needed to provide consistent, regular data on physician workforce needs to Congress, the administration and the public. This obstacle could be overcome by funding the Workforce Commission established in the Patient Protection and Affordable Care Act.

Emergency medicine residency programs train physicians to evaluate and respond to individual patient crises and man-made or natural disasters 24 hours-a-day, seven days-a-week. We look forward to working with you to ensure emergency medicine residency programs have an adequate, predictable and stable source of funds to maintain an appropriate supply of residency trained emergency medicine specialists to provide care for all Americans.

Sincerely,

Michael J. Gerardi, MD, FAAP, FACEP
President, ACEP