



April 19, 2023

The Honorable Brett Guthrie
House Energy and Commerce
Subcommittee on Health
2434 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Anna Eshoo
House Energy and Commerce
Subcommittee on Health
272 Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Guthrie and Ranking Member Eshoo,

On behalf of the American College of Emergency Physicians (ACEP) and our 40,000 members, I would like to thank you for holding this hearing, entitled, “Examining Existing Federal Programs to Build a Stronger Health Workforce and Improve Primary Care.” As emergency physicians who strive to provide high-quality, objective and evidence-based care, we share your concerns about the state of the health care workforce, especially as we continue to experience high levels of burnout, workplace violence, mental health challenges, and emergency department boarding. Regardless of these many challenges, emergency physicians are on the frontlines for all types of emergencies, and they are ready to do whatever is necessary, every day of the year, to care for patients during all manner of medical emergencies in the hospital and the event of public health crises, natural disasters, terrorist attacks, and many other scenarios. We appreciate the opportunity to share some of our experiences and suggestions on how to bolster federal programs and support for the health care workforce, and we look forward to continuing to work with you to improve patient access to care throughout our country.

The emergency department (ED) serves as the “front door” to the health care system, receiving more than 131 million visits in 2020, with more and more of our patients older in age and arriving via emergency medical services (EMS) transport. Of these visits, 16 to 18 percent of patients are admitted to the hospital, accounting for more than half of all inpatient admissions nationwide. And for many Americans, the ED may be the first – and only – interaction they have with the health care system, especially for safety-net and otherwise underserved populations.

Historically, emergency medicine has been one of the most-desired and fastest-growing physician specialties. Over the past five years, the number of positions offered for residency training in emergency medicine grew by 21 percent, compared to 16.5 percent for all specialties. Previous to this growth, emergency medicine residency programs routinely filled 99 percent of their available positions in the annual Match. However, over the last two residency application cycles, the number of unfilled residency spots has grown at an unprecedented rate, with 219 emergency residency positions unfilled in the 2022 match, and another even sharper increase to 555 unfilled in the 2023 initial match. While emergency medicine remains a vibrant and appealing specialty, our community is working to identify and better understand the factors contributing to the imbalance between growth and interest and develop strategies to mitigate them. Informed speculation about many of the factors leading applicants to opt for other specialties includes: burnout from violence and boarding in our nations emergency departments; concerns about projections of potential workforce oversupply; a shift to more programs being developed by non-academic hospitals that are less constrained by traditional GME funding caps; ongoing impact of the COVID-19 pandemic; economic challenges and the corporatization of medicine; growing use of physician assistants (PAs) and nurse practitioners (NPs) as lower-cost substitutes unable to provide high quality care; and many others. To better identify, understand, and respond to these various factors, a broad group of emergency medicine organizations have convened to establish a Match Task Force to develop strategies to mitigate these issues and establish an

WASHINGTON, DC OFFICE

901 New York Ave, NW
Suite 515E
Washington DC 20001-4432

202-728-0610
800-320-0610
www.acep.org

BOARD OF DIRECTORS

Christopher S. Kang, MD, FACEP
President
Aisha T. Terry, MD, MPH, FACEP
President-Elect
L. Anthony Cirillo, MD, FACEP
Chair of the Board
John T. Finnell, MD, MSc, FACEP
Vice President
James L. Shoemaker, Jr., MD, FACEP
Secretary-Treasurer
Gillian R. Schmitz, MD, FACEP
Immediate Past President
Jeffrey M. Goodloe, MD, FACEP
Allison J. Haddock, MD, FACEP
Gabor D. Kelen, MD, FACEP
Rami R. Khoury, MD, FACEP
Heidi C. Knowles, MD, FACEP
Kristin B. McCabe-Kline, MD, FACEP
Ryan A. Stanton, MD, FACEP

COUNCIL OFFICERS

Kelly Gray-Eurom, MD, MMM, FACEP
Speaker
Melissa W. Costello, MD, FACEP
Vice Speaker

EXECUTIVE DIRECTOR

Susan E. Sedory, MA, CAE

appropriate path forward. While this is a challenging time for emergency medicine, it is also one of opportunity, and the specialty remains one of the most popular for next generations of physicians.

But even despite the growth of the specialty and the overall supply of emergency physicians, we face challenges similar to those of our primary care and behavioral health colleagues in terms of maldistribution in rural and underserved communities. Workforce shortages are especially pronounced in rural and underserved areas throughout the country, and numerous barriers to providing equitable care in these communities persist. Among these are the inability to recruit qualified and sufficiently experienced, educated, and trained physicians, nurses, ancillary support staff, and other health care providers. Despite a 28 percent increase in emergency medicine residency positions over the past 10 years, there has been no corresponding increase in emergency medicine residency trained or emergency medicine board certified physicians working in rural EDs. Like the other issues noted here, this too is a complex problem due to a variety of factors, including limited opportunities for exposure to these communities during residency training, fewer full time employment opportunities overall due to ED staffing requirements and continued rural facility closures, a lack of recruitment tools and incentives such as those provided for primary care professions, among many others. Additionally, rural EDs, compared to their urban counterparts, are resource limited, financially stressed, and experience higher interfacility transfer rates. And while the COVID-19 pandemic increased the use of telehealth, rural areas still suffer from inconsistent availability of telehealth access and structural challenges like limited or functionally nonexistent broadband access. Transportation issues also limit many individuals' ability to reach hospitals, and emergency medical services (EMS) in rural areas also experience significant transportation delays due to issues with crew availability.

In order to attract more emergency physicians to rural and underserved communities, Congress can build off of existing designations and programs aimed at bolstering the rural health care workforce. Congress should consider establishing an Emergency Medicine Health Professional Shortage Area (HPSA), based on the existing criteria for HPSAs for mental health and primary care professionals (42 CFR Part 5), as well as ensuring that emergency physicians are eligible for student loan repayment assistance through the National Health Service Corps (NHSC) Loan Repayment Program for qualifying service in an approved site within such an emergency medicine HPSA. Another challenge in recruiting qualified health professionals to rural areas is that while an individual physician may seek or be afforded such an opportunity, their spouse or partner may not have the same employment opportunities, ability to move, or may face other barriers like occupational licensing and credentialing. Congress could help facilitate such transitions by implementing employment assistance programs similar to those that already exist for members of the Armed Services and their spouses. This could include federal hiring preferences and priority placement programs, licensure and recertification reimbursement, employment fellowship opportunities, and additional relocation and placement support for qualified spouses and partners.

The recently-established Rural Emergency Hospital (REH) designation for facilities in rural areas, a concept for which ACEP has long advocated, also has the potential to improve access to quality emergency care in certain rural areas, especially those affected by recent hospital closures. ACEP believes that all services delivered in REHs should be overseen by board-certified emergency physicians, though we acknowledge that this is not always possible due to existing workforce shortages in rural areas. We have urged CMS to require that in cases where a board-certified emergency physician is not available, a physician with training and/or experience in emergency medicine (such as a family physician) provide the care or oversee the care delivered by non-physician practitioners.

Under the REH designation, covered outpatient department services provided by an REH will receive an additional five percent payment for each service. Beneficiaries will not be charged a copayment on the additional five percent payment. CMS is proposing to consider all covered outpatient department services that would otherwise be paid under the Outpatient Prospective Payment System (OPPS) as REH services in these facilities. REHs would be paid for furnishing REH services at a rate that is equal to the OPPS payment rate for the equivalent covered outpatient department service, increased by five percent. CMS is also proposing that REHs may provide outpatient services that are not otherwise paid under the OPPS as well as post-hospital extended care services furnished in a unit of the facility that is a distinct part of the facility licensed as a skilled nursing facility; however, these services would not be considered REH services and therefore would be paid under the applicable fee schedule and would not receive the additional five percent payment increase that CMS proposes to apply to REH services. Finally, CMS is proposing that REHs would also receive a monthly facility payment. After the initial payment is established in calendar year (CY) 2023, the payment amount will increase in subsequent years by the hospital market basket percentage increase.

ACEP supports this payment approach as it aligns with the methodology outlined in the Consolidated Appropriations Act of 2020. However, we also note that the statute only addresses additional facility payments to REHs under the OPPS—not added reimbursement for physicians and other clinicians under the Physician Fee Schedule (PFS) who actually deliver the services in REHs. **In order to incentivize physicians and other clinicians to work in rural areas and appropriately staff REHs, ACEP strongly recommends that CMS consider creating an add-on code or modifier that clinicians could append to**

claims for services delivered in REHs. CMS could consider setting the value of this add-on code or modifier at five percent of the PFS rate for each Current Procedural Terminology (CPT) code that is billed—consistent with the additional OPPS payment that the statute provides. We urge the Congress to consider this approach as well.

Some have proposed expanding the scope of practice of nonphysician professionals in order to increase access to care, especially in rural and underserved communities. However, in reviewing the actual practice locations of nurse practitioners and primary care physicians, it is clear nurse practitioners and primary care physicians tend to work in the same large urban areas. There remain significant shortages of nurse practitioners in rural areas—the very problem with physician access that scope expansion has sought to address. This occurs regardless of the level of autonomy granted to nurse practitioners at the state level.

We also hope the Committee's examination of current health care workforce shortages will include a focus on the ongoing nursing shortages and the perverse incentives created by a growing over-reliance on over-priced nurse staffing agencies that have resulted in exorbitant increases in costs to already-strained health care systems. The extreme physical and mental toll of the COVID-19 pandemic response has inflicted enormous trauma and stress on physicians and nurses, resulting in increased burnout and dissatisfaction for those on the front lines and greater attrition in the health care workforce. This has left many health systems, who even before the pandemic often had to rely on mandatory overtime and other stopgap measures to ensure an adequate nurse workforce, desperate to fill workforce gaps by relying on nurse staffing agencies, some of whom have imposed extreme rate hikes to supply travel nurses to hospitals. This in turn draws off even more nurses previously employed in hospitals, given the higher pay and greater autonomy over their own working conditions. In many cases, facilities have been left with no other choice than to pay substantially inflated rates in their attempts to maintain staffing levels capable of meeting their community's needs. We appreciate Congress' recent attention to this issue and encourage continued investigation and oversight of potentially anticompetitive practices occurring in the health care workplace.

We believe that the ongoing challenges in recruiting and retaining all levels of health care professionals in rural and underserved areas are more complex, and that this persistent issue requires more innovative solutions to incentivize physicians and other health care professionals to work in these communities. We would welcome the opportunity to work with you and your colleagues to find more effective and durable solutions to these longstanding workforce challenges to ensure that Americans in rural and underserved areas have access to high-quality emergency care, recognizing the level of expertise and training required for independent practice of emergency medicine and supporting the provision of physician-led team-based care.

Once again, thank you for the opportunity to provide our perspective on the issues facing the health care workforce, especially for the communities that are most in need of expanded access to care. We look forward to working with you during the 118th Congress to help ensure that our emergency medicine workforce is strong enough to support our patients, their families, and our communities. Should you have any questions or require any further information, please do not hesitate to contact Ryan McBride, ACEP's Congressional Affairs Director, at rmcbride@acep.org.

Sincerely,



Christopher S. Kang, MD, FACEP
ACEP President