American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

February 27, 2025

To the Members of the 119th Congress:

On behalf of the American College of Emergency Physicians (ACEP) and our nearly 40,000 members, we look forward to working with you and your staff to ensure continued access to the affordable, lifesaving emergency care that our patients and communities depend upon. The emergency department (ED) serves as the "front door" to the health care system, receiving 140 million visits in 2021[1], with more and more of our patients older in age and arriving via emergency medical services (EMS) transport. 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.

As we work to care for our patients, we are eager to continue partnering with Congress to identify challenges and develop policy solutions that will improve and sustain our nation's emergency care framework. Emergency physicians stand ready for our patients 24 hours a day, 7 days a week, 365 days a year, and likewise, ACEP always stands ready to work with and serve as a resource to you and your staff.

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

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

We appreciate the opportunity to share with you some of the key priorities for and challenges facing emergency medicine. These include stabilizing the health care safety net by addressing conditions and factors that lead to "boarding" and crowding in emergency departments, a crisis overwhelming EDs across the country, straining the physician and nursing workforce, and even causing avoidable patient deaths; addressing bad insurer practices and behavior; protecting emergency physicians, nurses, and staff from violence in the ED; improving access to care for those in mental health crisis, and providing more pathways to recovery for patients with substance use disorders; promoting research in emergency medicine, public health, and injury prevention efforts; and, ensuring fairness and stability for emergency medicine through necessary reforms to Medicare physician payments and protecting the viability of the Medicaid program that covers so many of our patients, among many others.

Emergency Department Boarding

Patient "boarding" occurs when a patient continues to occupy an ED bed even after being seen and treated by a physician, while waiting to be admitted to an inpatient bed in the hospital, or transferred to psychiatric, skilled nursing, or other specialty facility. A direct result of hospital system overload as our health care system becomes increasingly strained, these patients must stay in the ED for days or even weeks on end waiting for a bed to become available so they can be admitted or transferred. Patients being boarded in the ED limits the ability of ED staff to provide timely and quality care to all patients, forcing other newly arriving patients with equally important emergency conditions to wait in the ED waiting room for care, with wait times as long as eight or even twelve hours rapidly becoming a new norm, and patients even dying during these waits as staff struggle to keep up with an unsupportable volume of sick patients to care for.

Our nation's safety net is on the verge of breaking beyond repair; EDs are gridlocked and overwhelmed with patients waiting – waiting to be seen, waiting for admission into an inpatient bed in the hospital, waiting to be transferred to psychiatric, skilled nursing, or other specialized

[1] https://www.cdc.gov/nchs/fastats/emergency-department.htm

facilities that have little to no available beds, or, waiting to simply return to their nursing home. And this breaking point is entirely outside of the control of highly skilled emergency physicians, nurses, and other ED staff doing their best to keep everyone attended to and alive.

Any emergency patient can find themselves boarded, regardless of their condition, age, insurance coverage, income, or geographic area. Even patients sick enough to need intensive care may board for hours in ED stretchers not set up for the extra monitoring they need. Those in mental health crises, often children or adolescents, board for *months* in chaotic EDs while waiting for a psychiatric inpatient bed to open anywhere. But boarding does not just affect those waiting to receive care elsewhere. When ED beds are already filled with boarded patients, other patients are decompensating and, in some cases, dying while in ED waiting rooms during their tenth, eleventh, or even twelfth hour of waiting to be seen by a physician.

> *"At peak times which occur up to 5 days per week we have more patients boarding than we have staffed beds. High numbers have include last week when our 22 bed emergency department had 35 boarders and an additional 20 patients in the waiting room…In addition, we have patients who unfortunately have died in our waiting room while awaiting treatment. These deaths were entirely due to boarding. Our boarding numbers have unfortunately skyrocketed in the wake of COVID as a consequence of increasing surgical volumes and decreasing inpatient nurse staffing."*
>
> – anonymous emergency physician

To illustrate the stark reality of this crisis, ACEP asked its members to share examples of the life-threatening impacts of ED boarding. The stories paint a picture of an emergency care system already near collapse. While the causes of ED boarding are multifactorial, unprecedented and rising staffing shortages throughout the health care system have recently brought this issue to a crisis point, further spiraling the stress and burnout driving the current exodus of excellent physicians, nurses, paramedics, and other health care professionals.

We need a health care system that can accurately track available beds and other relevant data in real-time, appropriate metrics to measure ED throughput and boarding, contingency plans and "load balancing" plans for boarding/crowding scenarios, and fewer regulatory or other "red tape" burdens that delay necessary care. Recognizing all EDs are different and there is no one-size-fits-all solution to this multifactorial problem, ACEP is in the process of developing a broad range of potential legislative and regulatory solutions that will alleviate the burdens and overall strain on EDs caused by patient boarding. As we finalize these recommendations and policy solutions, we will share more broadly with you and your staff in the coming weeks. Further, we strongly urge Congress to direct its attention to this critical issue and work with us and other stakeholders through roundtables, hearings, and legislation to provide both short- and long-term solutions to this public health crisis.

Stopping Bad Insurer Behavior

Whether through explicit violations of the No Surprises Act, abuse of prior authorization procedures, frequent attempts to undermine and erode the federal prudent layperson standard, or outright denials of necessary care, insurers continue to exploit our health care system and the individuals and families they ostensibly cover, all for the sake of increasing their record profits. ACEP strongly supports the enforcement of laws and regulations meant to halt these patterns of bad behavior that have only become more egregious over the course of recent years.

Emergency physicians provide care under circumstances and laws that are unique among other physician and provider specialties. We provide more uncompensated care than any other physicians, as the federal Emergency Medical Treatment and Labor Act (EMTALA) requires that anyone coming to an emergency department must be stabilized and treated, regardless of their insurance status or ability to pay. The burden of uncompensated care only continues to grow, particularly in communities with high populations of uninsured patients. Additionally, in order to ensure 24/7/365 access to the emergency department, we work under more specialized staff and standby requirements than other types of medical providers so that we can meet the needs of patients who experience a wide range of emergencies every day such as heart attacks, strokes, trauma, mental health conditions, and countless others. Unfortunately, many insurers continue to exploit these unique circumstances that harm physician practices and put patients at risk.

For more than twenty years, the prudent layperson standard (PLS) has protected patients from being subjected to retroactive denials by health insurers. Patients should not be afraid to visit the ED for fear their insurance will not cover their visit – if you think you are having a medical emergency, you should seek emergency care. That has not stopped health plans from trying to skirt the law, using scare tactics to prevent people from seeking emergency care, and denying or downcoding claims based on final diagnoses rather than the presenting symptoms that initially brought the patient to the ED seeking treatment.

With respect to the No Surprises Act, Congress passed a bipartisan, bicameral bill to establish critical safeguards to protect patients from out-of-network billing disputes between health care providers and insurers, while not tilting the carefully-crafted independent dispute resolution (IDR) process in favor of either party. However, in the time since this landmark federal protection was signed into law in 2020 as part of the Consolidated Appropriations Act, 2021 (P.L. 116-260), insurers have flagrantly abused the flawed implementation of the law and have even exploited the regulations in attempts to strongarm physician groups into accepting drastic cuts to longstanding **in-network** contracts. Plans also continue to exploit the IDR process, either on the front end through deliberate delay tactics or intentionally low initial payments, or on the back end by repeatedly failing to pay physicians within the 30-day period (if at all) after losing a dispute as required by the law. A 2024 member survey by the Emergency Department Practice Management Association (EDPMA) found that in disputes where the provider was the prevailing party, 24 percent of the payments owed by health plans to providers were either unpaid or paid incorrectly within the statutorily-required period.

This abuse is not limited solely at physicians and providers – more concerningly, many practices have reported that health plans have at times increased the patient cost-sharing amounts **after** an IDR determination, fundamentally undermining the fundamental cornerstone goal of the NSA in removing patients from the middle of billing disputes between insurers and providers. While subsequent legal decisions have helped bring the No Surprises Act closer to congressional intent, there is still work to be done to fully implement the law appropriately as Congress truly intended.

During the 118th Congress, ACEP strongly supported the No Surprises Act Enforcement Act (H.R. 9572/S. 5535), bipartisan legislation led by Reps. Greg Murphy, MD (R-NC), Raul Ruiz, MD (D-CA), John Joyce (R-PA), Kim Schrier, MD (D-WA), and Jimmy Panetta (D-CA) in the House and Sens. Roger Marshall, MD (R-KS) and Michael Bennet (D-CO) in the Senate. This straightforward legislation reinforces the No Surprises Act by closing enforcement gaps through increased penalties for non-compliance of statutory payment deadlines, providing parity between penalties imposed against parties non-compliant with statutory patient protection provisions, and increasing transparency in reporting requirements. ACEP urges legislators to cosponsor and support this legislation when reintroduced. We further ask Congress to continue its critical oversight role to ensure proper implementation of the NSA per clear congressional intent and to address the myriad examples of bad insurer practices that harm patients and their health care providers.

Protecting Emergency Medicine & Fulfilling Medicare's Promise to Seniors

As Congress examines policies that could significantly alter the Medicaid program, we strongly urge legislators to recognize the dramatic impacts that some proposed policy changes could have on the emergency care safety net and the patients we serve. Medicaid reforms should seek to protect access to emergency care for all who need it, while at the same time promoting fiscal responsibility and the provision of quality care. ACEP understands and shares Congress' commitment to preventing waste, fraud, and abuse of taxpayer dollars in Medicaid and any federal health programs. We recognize that there is a broad framework of proposed changes to Medicaid and understand that not all of the various proposals may be considered, but we are deeply concerned by the scope and scale of possible cuts that could soon hit Medicaid given the reality of the substantial savings targets that will be sought in the budget reconciliation process. Sweeping and dramatic cuts to Medicaid have the potential to be catastrophic for our already-overburdened emergency departments nationwide, especially if savings from policy changes are not reinvested into efforts to improve access to high-quality health care. Already limited federal health care dollars must go back into the health care system. **When considering our continued obligation under EMTALA to provide care to any patient, any time, regardless of insurance status or ability to pay**, we will not be able to withstand a cost-shift of this magnitude that will be focused squarely on emergency medicine. Additionally, there are few – if any – states equipped with the resources or budgets to fully absorb the impacts of many proposed significant changes.

The cumulative negative impact of continued payment rate cuts to physicians and providers has resulted in fewer community providers accepting Medicaid patients, forcing more and more patients to seek costlier care in the emergency department. This exacerbates existing access to care challenges for Medicaid patients especially, and results in increased overall health care costs. Further reducing payment rates to hospitals and physicians who provide emergency care in the ED will jeopardize Medicaid patient population access to emergency care when it is needed most. Tightening eligibility requirements to reduce the size of the Medicaid patient population simply forces more individuals into the ranks of the uninsured, affecting their access to care and resulting in additional uncompensated care that further strains emergency departments, hospitals, and states. According to a recent KFF estimate, just eliminating the current Federal Medical Assistance Percentage (FMAP) under the Affordable Care Act expansion could reduce Medicaid spending by nearly one-fifth, but would result in nearly 20 million people losing access to Medicaid coverage. Emergency physicians already provide more uncompensated care than any other physician specialty, and the

added financial strain due to such a surge of uninsured individuals – potentially in the tens of millions – who need emergency care may very well collapse health systems that are already at their limit.

Investing in increased access to alternate sites of care for non-emergency Medicaid patients, such as increasing access to hospital clinics, outpatient clinics, expanding physician office hours, or improving access to transportation, would result in a more efficient utilization of limited health care dollars and help to decrease non-emergency, expensive emergency department usage by Medicaid patients who have no other site to obtain primary care. This initial upfront investment would pay off in decreased overall costs in the long run, and would also promote more preventive care among the Medicaid population, leading to higher quality of care and lower costs to the health care system on the whole.

There are several very effective mechanisms for cost savings that provide true, clear benefits to patients, hospitals, physicians, and payors alike: increasing access to primary care, increased care coordination, health information exchanges (HIEs), and alternative payment models. These tools improve the efficiency of health care dollars spent by encouraging and enabling appropriate use of the health care system before, during, and after an ED visit. Increasing access to primary care and care coordination have shown to decrease costs by helping patients stay healthier, thus avoiding the need for an ED visit rather than waiting for a health concern or condition to worsen. HIEs decrease the cost of care once a patient is in the ED by decreasing utilization and duplication of scarce health care resources. Seeing as the most expensive decision in health care is whether or not to hospitalize a patient from the ED, alternative payment models for emergency physicians are a very powerful tool for cost savings, allowing the safe use of outpatient resources after an ED encounter rather than the need for full hospitalization. The growing number of examples of such effective mechanisms for cost savings at the state level further demonstrate the keys to successful implementation in the future. As Congress and states alike look to contain Medicaid costs and ensure appropriate stewardship of hard-earned taxpayer dollars, these examples will be informative for future health policy discussions. Additional background and data on such examples can be found in ACEP's "Medicaid Cost Saving Measures for Emergency Care" information paper.

With respect to Medicare, financial stability and certainty are critical in ensuring that Medicare can fulfill its promise to the millions of American seniors that deserve and depend upon this program. The annual issue of significant Medicare physician payment cuts not only threatens the viability of the health care safety net, but also affects our ability to effectively partner with Congress to address other critical challenges facing the physician community, and most importantly, our ability to advocate on behalf of our patients. We share legislators' significant frustrations with the perennial task of finding costly, short-term fixes for long-term problems, and to this end, we support efforts to provide greater and stability and certainty in this system.

While the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 helped avoid short-term physician payment issues, according to the 2022 Medicare Trustees Report there are "…important long-range concerns that will almost certainly need to be addressed by future legislation." The Trustees noted that without changes, future access to Medicare-participating physicians will become a significant long-term problem. ACEP strongly agrees with this assessment.

In the short term, we strongly urge Congress to take immediate action to fully reverse the 2.38 percent Medicare Physician Fee Schedule (PFS) conversion factor (CF) cut that went into effect on January 1, 2025, and provide clinicians with a positive payment update to help account for inflationary pressures that are currently not reflected in the Medicare physician payment system. Since 2020, Congress has mitigated the full impact of the annual reductions in the PFS, but even despite this relief, 2025 marks the fifth consecutive year of cuts to Medicare physician reimbursements. The impact of these cuts is compounded by the fact that the PFS has no inflationary update, even though other Medicare participants receive annual payment updates. We ask you to cosponsor and support swift passage of H.R. 879, the bipartisan Medicare Patient Access and Practice Stabilization Act, and ensure that these cuts are immediately reversed in the next government funding package.

Overall, we believe that with improvements, developed through collaboration with Congress, regulators, and stakeholders as originally intended, MACRA can be significantly more effective in facilitating the transition to value based care delivery. It does not necessitate the wholesale dismantling of the current system as we did with the SGR, but does require more regular oversight and iteration to help us attain a sustainable payment system that truly incentivizes high-quality, cost-effective care and to ensure that we do not expend our time and resources in vain trying to achieve that ultimate goal. ACEP was encouraged by previous efforts in 2022 requesting information from stakeholders on how Congress can stabilize the Medicare payment system without dramatic increases in Medicare spending, while ensuring successful value-based care incentives are in place. We ask Congress to work with us to identify long-term, substantive reforms by holding hearings and roundtables to explore potential solutions that will guarantee the stability and security of the Medicare program, ensuring our nation's seniors have access to the high-quality care they need and deserve.

Ensuring a Robust Federal Health Infrastructure

ACEP respectfully calls upon Congress and the Administration to recognize the critical importance of a robust federal health infrastructure in safeguarding the prosperity and security of our nation, and the health and well-being of our people.

As noted above, emergency physicians proudly serve as the country's safety net, providing high-quality care to 140 million patients annually. This safety net is reinforced in large part by the work of numerous federal agencies. For example, the Administration for Strategic Preparedness and Response (ASPR) enhances our readiness to respond to disasters, mass casualty events, and national security threats, such as bioterrorism, chemical, or even nuclear attacks. The Centers for Medicare and Medicaid Services (CMS) provides vital data, payment frameworks, and resources that are mission-critical to caring for all Americans, particularly rural populations and especially our seniors who have earned and deserve the promise of the Medicare program. The Centers for Disease Control and Prevention (CDC) monitors and responds to public health threats, with evidence-based protocols for emergency preparedness, providing real-time data during health crises, and offering training and resources that enhance the readiness and resilience of emergency care systems. The National Institutes of Health (NIH) provides groundbreaking research that informs clinical practices, develops innovative treatments and medical technologies, and fosters scientific discoveries that significantly improve patient outcomes in acute care settings.

These non-exhaustive examples underscore the indispensable role of federal resources in enabling emergency physicians to provide lifesaving care to all – 24 hours a day, 7 days a week, 365 days a year.

As the Administration continues its efforts to streamline government operations, deliver greater efficiencies, and reduce unnecessary expenditures, we hope Congress will encourage a thoughtful, precision-based approach—a scalpel rather than a blunt instrument when evaluating departments and agencies particularly within Health & Human Services (HHS). We also emphasize the importance of maintaining public access to critical data sources and evidence-based information—resources that represent decades of federal investment and are pivotal for informed decision-making in both public health and clinical care.

Given our unique role as frontline clinicians who must be prepared to address a wide array of medical emergencies and disaster scenarios, we deeply value our partnerships with federal agencies. Too drastic a reduction in the federal health workforce risks compromising these vital collaborations, potentially posing a national security concern by weakening our collective ability to respond to crises and threatening patient access to lifesaving emergency care. We stand ready to work collaboratively with Congress, HHS, and other federal health agencies to ensure that our nation's health care safety net remains strong and capable of delivering the lifesaving care that Americans need and deserve.

Violence Against Emergency Physicians and Health Care Workers

Violence in the emergency department is a serious and growing concern, causing significant stress to emergency department staff and to patients who seek treatment in the emergency department (ED). According to a survey conducted by ACEP in 2022, two-thirds of emergency physicians report being assaulted in the past year alone, while more than one-third of respondents say they have been assaulted more than once. Nearly 85 percent of emergency physicians say the rate of ED violence has increased within the last year.

Beyond the immediate physical impacts and injuries, the risk of violence increases the difficulty of recruiting and retaining qualified health care professionals and contributes to greater levels of physician burnout. In fact, 87% of emergency physicians report a loss of productivity from the physician or staff as a result, and 85% of emergency physicians report emotional trauma and an increase in anxiety because of ED violence. Most importantly, patients with medical emergencies deserve high-quality care in a place free of physical dangers from other patients or individuals, and care from staff that is not distracted by individuals with behavioral or substance-induced violent behavior.

And unlike the significantly more visible violence against airline employees and other travelers that has become more ubiquitous over the last several years, violence against health care workers often is not seen or addressed because of inadequate reporting and tracking of violent incidents, and other systemic barriers that do not hold violent individuals accountable for their actions. As a result of the inability to prosecute those who are arrested, many health care workers are discouraged from even pressing charges and being forced to accept that it's "just part of the job." **Violence is not accepted in any other workplace, and it must not be accepted especially in a setting focused on improving the health and well-being of individuals**.

There are many factors contributing to the increase in ED and hospital violence, we recognize there is no one-size-fits-all solution to this issue either. In fact, one of the challenges is that the types of violence one ED typically experiences can be significantly different from another ED, even in the same town. Therefore, ensuring there are adequate resources to help identify best practices and outfitting facilities with resources appropriate to their specific needs is imperative. Overall, employers and hospitals should develop workplace violence prevention and response procedures that address the needs of their particular facilities, staff, contractors, and communities, as those needs and resources may vary significantly.

We ask Congress to consider federal efforts to address, reduce, and prevent the threat and incidence of violence against emergency physicians and other health care workers.

Access to Mental Health Care

The emergency department is not only a safety net for those with physical care needs, but also for individuals suffering from a mental health crisis or acute psychiatric emergency. However, it is not ideal for long-term treatment of mental and behavioral health needs. Due to the fragmented nature of the mental health care infrastructure in the U.S., persistent lack of sufficient resources, and longstanding shortages of mental and behavioral health professionals, far too many Americans have limited options for the longer-term follow-up treatment they need and deserve. These challenges also contribute to the long ED wait times and aggravate ED boarding issues detailed above. In fact, ED boarding challenges disproportionately affect patients with behavioral health needs who wait on average three times longer than medical patients because of these significant gaps in our health care system.

Across the country, communities have adopted innovative alternative models to improve emergency psychiatric care and reduce psychiatric patient boarding. These include Behavioral Health Emergency Rooms (BHERs), separate areas of the ED that specialize in caring for patients experiencing a behavioral health crisis; Emergency Psychiatric Assessment Treatment and Healing (EmPath) Units, a separate, hospital-based setting solely for psychiatric emergencies with the safe, calming, homelike environment of a community mental health crisis clinic but with the ED's ability to care for any patient presenting for treatment; and Psychiatric Emergency Service (PES) models, a "hub-and-spoke" model with a dedicated psychiatric ED serving as a central hub with bidirectional spokes going out to a wide variety of mental, behavioral, and physical care, as well as social services.

To ensure that communities can implement models that best fit their particular needs, ACEP supports the bipartisan "Improving Mental Health Access from the Emergency Department Act" (H.R. 5414/S. 1346 in the 118th Congress), led by Reps. Raul Ruiz (D-CA) and Brian Fitzpatrick (R-PA) and Sens. Shelley Moore Capito (R-WV) and Maggie Hassan (D-NH). This legislation would provide critical funding to help communities implement and expand programs to expedite transition to post-emergency care through expanded coordination with regional service providers, assessment, peer navigators, bed availability tracking and management, transfer protocol development, networking infrastructure development, and transportation services; increase the supply of inpatient psychiatric beds and alternative care settings; and, expand approaches to providing psychiatric care in the ED, including telepsychiatry, peak period crisis clinics, or dedicated psychiatric emergency service units. This legislation was passed by the House of Representatives during the 117th Congress, but was ultimately not considered by the Senate. We anticipate this bill will be reintroduced in the 119th Congress in the near future and urge legislators to consider and pass this important legislation.

In addition to the mental health needs of the public, ACEP also strongly urges Congress to continue working to address physician and provider mental health and burnout as part of larger policy efforts, especially in light of the significant mental health toll the pandemic response has taken on frontline health care providers. According to a recent report, 63 percent of emergency physicians reported burnout – the highest rate by a wide margin among the physician specialties surveyed. Improving and providing for the mental health and well-being of the health care workforce is a unique challenge, but one that is absolutely essential to ensure that patients have access to the full continuum of high-quality health care.

We are deeply grateful for Congress' bipartisan work to pass the Dr. Lorna Breen Health Care Provider Protection Act (P.L. 117-105), which was signed into law on March 18, 2022. This law was the first of its kind and only law dedicated to the specific need of addressing physician and health care provider mental health. The bipartisan, bicameral effort to reauthorize this law was passed with overwhelming support in both the House Energy and Commerce Committee and the Senate Health, Education, Labor, and Pensions (HELP) Committee during the 118th Congress and was slated to be included as part of the 2024 year-end health package, but as you well know, that health package was unfortunately not included in the December continuing resolution. The reauthorization legislation, H.R. 929/S. 266 has been reintroduced in the 119th Congress and we strongly urge you cosponsor and support this legislation to reauthorize the critical programs and resources provided under this law and ensure they are adequately funded to improve the mental health of the health care workforce.

Pandemic and All-Hazards Preparedness Act (PAHPA) Reauthorization

We must ensure that our country's public health and medical preparedness response capabilities are equipped to respond to future pandemics, outbreaks, natural disasters, deliberate attacks, and other mass casualty events. The Consolidated Appropriations Act, 2023, included efforts to improve medical countermeasure research and manufacturing capacity, strengthening the supply chain for essential medications, personal protective equipment (PPE), and other resources, and reinforcing the Strategic National Stockpile (SNS). However, there are still more steps we can take to improve our emergency preparedness infrastructure on all fronts through the Pandemic and All-Hazards Preparedness Act (PAHPA), which must still be fully reauthorized.

Among our priorities as Congress considers reauthorization are:

- Development of a robust, coordinated national trauma and emergency preparedness system that can provide awareness of resources and surge capacity throughout the health care system (as well as the ability to "load balance" the system to match patients with appropriate resources and specialty expertise);
- Additional efforts to incentivize and operationalize domestic production of essential emergency medications, equipment, and PPE and ensure that distribution of these resources is prioritized for frontline providers and responders;
- Reauthorization of the successful MISSION ZERO program that awards grants to enable military trauma care providers and trauma teams to provide trauma care and related acute care at civilian trauma centers (improving not only care provided in our communities but bolstering our military readiness capabilities);
- Protecting our emergency response systems and infrastructure from cyberattacks and other potential vulnerabilities; and,
- Promoting research through the NIH's Office of Emergency Care Research (OECR) to foster basic, translational, and clinical research and research training for the emergency setting.

Once again, thank you for the opportunity to share some of our priorities and issues affecting emergency medicine, and we look forward to working with you during the 119th Congress to help ensure that our health care safety net is there 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,

Alison J. Haddock, MD, FACEP
President, American College of Emergency Physicians