



March 18, 2024

The Honorable Jason Smith  
Chairman  
Committee on Ways and Means  
1139 Longworth House Office Building  
U.S. House of Representatives  
Washington, D.C. 20510

Dear Chairman Smith:

On behalf of the American College of Emergency Physicians (ACEP) and our nearly 40,000 members, thank you for the opportunity to share our comments for today’s field hearing, entitled, “Access to Health Care in America: Ensuring Resilient Emergency Medical Care.” Ensuring all patients have access to lifesaving emergency care, especially those in rural and underserved areas, is a key priority for ACEP and we are grateful for the opportunity to share our perspective on this critical issue.

As you well know, rural and underserved communities have their own unique sets of needs and challenges in providing appropriate, high-quality, and timely care, particularly for emergency care. Rural emergency departments (EDs) provide critical services for their communities while often operating under different constraints and with more limited resources than higher-density urban areas. These services include facilitating earlier evaluation and entry into the health care system, stabilization and initiation of treatment, and coordinated transfer to a tertiary care facility.

Among the challenges affecting patient outcomes and the practice of emergency medicine in rural areas are the ED patient “boarding” crisis, where admitted patients are held in the ED when there are no inpatient beds available; staffing issues, including recruitment, retention, and high variability in rural ED staffing; complexity and system fragmentation in transferring patients to appropriate settings; limited access to primary and specialty care; limited technological resources, including broadband, and continued closures of rural hospitals and other health care facilities that limit access to care in these communities.

ACEP thanks you for your continued attention to the health care needs of our patients, especially those in rural and underserved communities. We appreciate the opportunity to share our insights and suggestions in the following pages on policies that will help improve patient access to high-quality lifesaving emergency care.

Should you have any questions, please do not hesitate to reach out to Ryan McBride, ACEP Congressional Affairs Director, at [rmcbride@acep.org](mailto:rmcbride@acep.org).

Sincerely,

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## 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 a psychiatric, skilled nursing, or other specialty facility. 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, high-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 ways as staff struggle to keep up with an unsupportable volume of sick patients to care for.

**Boarding has become its own public health emergency.** 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 other specialized facilities that have few to no available beds, or, waiting simply to 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.

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. Below are several excerpts from anonymous emergency physicians describing the negative impacts of boarding on patient outcomes, including potentially avoidable deaths:

*“We are a very rural hospital with only family practice and emergency physicians - there are no specialists within 90 miles...Recently I had a woman with abdominal pain in the ER. When she arrived she had normal vital signs and was not really very sick. Testing showed that she had an infected gallbladder - a simple problem for any surgeon to treat. We called 27 hospitals before one in a different state called us back when a bed finally opened up. She spent thirty six hours in our ER, and was in shock being treated with maximum doses of drugs to keep her alive when she was transferred. She didn't survive.”*

*“My shop is 34 bed rural tertiary care center that serves an area greater than 20,000 square miles. Month after month our boarding issues continue to exacerbate and have surpassed critical levels many months ago. We are frequently the largest in-patient ward in the hospital. Currently we average 28 boarding patients in our department and this has been as high as 41 boarded inpatients and 31 patients in the waiting room less than a week ago...Due to these challenges we have fully implemented “waiting room medicine”, closed down our Provider in Triage, instead all providers pickup patients in the waiting room. Nearly 50% of our patient encounters now result in discharge from the waiting room. Finally, it is not at all uncommon to have patients in the waiting room with SarsCoV-2, pending orders for heparin, diltazem, or other vasoactive medications. In the past month we have had SAH [subarachnoid hemorrhage, or brain bleed], Fournier gangrene, hip fractures, septic shock all being treated in the waiting room with no available beds to move them into.”*

*“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.”*

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 has helped develop and supports a broad range of potential legislative

and regulatory solutions that will alleviate the burdens and overall strain on EDs caused by patient boarding. 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.

### **Geographic Payment Differences**

The Medicare Physician Fee Schedule (PFS) includes payment adjustments based on several factors to account for geographic variations in the cost of providing care in different areas. Among the three Geographic Practice Cost Indices (GPCIs), the physician work GPCI adjust payments based on the relative costs associated with a physician's labor (time, skill, and effort) compared to the national average. For years, Congress has almost annually set a GPCI work "floor" of 1.00 to help any localities with a low work GPCI, often rural and underserved areas, by increasing Medicare payments to physicians practicing in these localities.

Without an extension of the current work floor, rural communities will be the hardest hit, as physicians practicing in these communities will see an *additional* payment reduction on top of other impending cuts to Medicare physician reimbursement. As you well know, rural communities face significant, unique challenges in recruiting and retaining physicians, and continued payment cuts will only serve to further destabilize the health care safety net in communities where access to care is already limited. ACEP appreciates Congress' recent work to extend the work floor through December 31, 2024, and urges Congress to, at the very least, maintain the current 1.00 Medicare work floor going forward.

### **Sustainable Provider and Facility Financing**

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 receive an additional five percent payment for each service. Beneficiaries will not be charged a copayment on the additional five percent payment. CMS considers all covered outpatient department services that would otherwise be paid under the Outpatient Prospective Payment System (OPPS) as REH services in these facilities. REHs will 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. 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 are not considered REH services and therefore are paid under the applicable fee schedule and do not receive the additional five percent payment increase that CMS applies to REH services. Finally, REHs also receive a monthly facility payment, and this 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. The additional money the hospitals receive is for their own unique rural needs and therefore does not flow down to the emergency physicians that staff those rural EDs (especially because most emergency physicians are not salaried direct employees of the hospital). **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.** However, to date CMS has not established such a code or modifier. We therefore urge the Committee to consider and support this approach as well to help ensure that REHs are appropriately staffed.

## Aligning Sites of Service

In rural or underserved communities where there is no access to a hospital or REH, freestanding emergency departments (FSEDs) could help alleviate issues of limited access to emergency care. There are two distinct types of FSEDs: a hospital outpatient department (HOPD), often referred to as an off-site hospital-based or satellite ED, and independent freestanding emergency centers (IFECs). HOPDs are owned and operated by medical centers or hospital systems, and under federal law and regulations, if the medical center or hospital system accepts Medicare or Medicaid payments for emergency services at an HOPD, the HOPD falls under the same rules and regulations of CMS as the ED of the medical center or hospital, and therefore must comply with all CMS Conditions of Participation (CoPs).

IFECs may be owned by any individual or business entity. Some states have created licensing criteria to govern IFECs that closely follow or mirror the intent of the Emergency Medical Treatment and Labor Act (EMTALA), as well as other rules and regulations. Many states still do not currently address licensing rules for IFECs, and, currently, CMS does not recognize IFECs as EDs, meaning that CMS does not allow for Medicare or Medicaid payment for the technical component of services provided by these facilities (physicians may submit professional fees and be reimbursed under Medicare for the professional component, however).

ACEP believes that any FSED facility that presents itself as an ED, regardless of whether it is an HOPD or IFEC, should:

- Be available to the public 24 hours a day, seven days a week, 365 days per year;
- Be staffed by appropriately qualified emergency physicians;
- Have adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility;
- Be staffed at all times by a registered nurse (RN) with a minimum requirement of current certification in advanced cardiac life support and pediatric advanced life support;
- Have policy agreements and procedures in place to provide effective and efficient transfer to a higher level of care if needed (i.e., cath labs, surgery, ICU); and,
- Receive the same level of reimbursement for both the physician and technical component fee as a traditional hospital-based emergency department.

Further, ACEP believes that all FSEDs must follow the intent of the EMTALA statute and that all individuals arriving at an FSED should be provided an appropriate medical screening examination (MSE) by qualified medical personnel including ancillary services, to determine whether or not an emergency exists.

Under regulatory flexibilities provided under the COVID-19 public health emergency (PHE), CMS issued waivers in April 2020 to allow IFECs to enroll as Medicare-certified hospitals and receive reimbursement under Medicare as a method of expanding provider capacity. But with the expiration of the COVID-19 PHE on May 11, 2023, this waiver also expired and IFECs are no longer able to be reimbursed for the technical component under Medicare, despite a recent [study](#) finding that IFECs did not increase overall utilization of emergency care services and that payments were actually more than 20 percent *lower* than for those in hospital-based EDs. We therefore encourage the Committee to consider and support the bipartisan “Emergency Care Improvement Act,” (H.R. 1694), introduced by Representatives Jodey Arrington (R-TX) and Vicente Gonzalez (D-TX), to permanently recognize these facilities under Medicare and Medicaid.

## Health Care Workforce

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.

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 (NPs) 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 NPs at the state level.

We believe the gold standard for care in an emergency department is via a physician-led emergency care team, with that care performed or supervised by a board-certified/board-eligible emergency physician. Physician Assistants (PAs) and NPs can and do serve integral roles as members of the emergency care team, but do not replace the medical expertise provided by emergency physicians. The physician-led emergency care team is the safest care model for our patients and particularly important for Medicare beneficiaries, who are some of the most medically vulnerable patients in our population, often suffering from multiple chronic conditions or other complex medical needs and account for nearly 20 percent of ED encounters each year.

While non-physician practitioners are indispensable partners in a care setting, there are meaningful differences in the training that each member of the care team receives. In fact, there is evidence that scope expansion can lead to [overprescribing](#) and [overutilization of diagnostic imaging](#), or other services. For example, in states that allow independent prescribing, nurse practitioners were 20 times more likely to overprescribe opioids than those in prescription-restricted states. In another study, non-physicians were found to have ordered more imaging over a 12-year period, according to another study. Scans increased more than 400% by non-physicians, primarily nurse practitioners and physician assistants. Specifically in the emergency department, an October 2022 Stanford University study found that nurse practitioners use more resources and achieve worse outcomes than physicians, especially when dealing with complex patients – a 7 percent increase in cost of ED care, an 11 percent increase in length of ED stay, and a 20 percent increase in 30-day preventable hospitalizations. This can have a devastating effect on the patients overall health care and further strain the health care system.

Supporting physician-led health care teams is also aligned with most state scope of practice laws. For example, over 40 states require physician supervision of or collaboration with PAs. Most states require physician supervision of or collaboration with nurse anesthetists, and 35 states require some physician supervision of or collaboration with nurse practitioners, including populous states like California, Florida, New York, and Texas. These states represent more than 85 percent of the U.S. population. Moreover, despite multiple attempts, in the last five years no state has enacted legislation to allow nurse practitioners full-immediate independent practice.

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.