

March 20, 2023

The Honorable Bernie Sanders
Chair
Senate Health, Education, Labor, and
Pensions Committee
428 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Bill Cassidy, MD
Ranking Member
Senate Health, Education, Labor, and
Pensions Committee
428 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Sanders and Ranking Member Cassidy,

On behalf of the American College of Emergency Physicians (ACEP) and our 40,000 members, I would like to thank you for providing the opportunity to share our ideas on the root causes of and solutions to the health care workforce shortages affecting communities across the country. Emergency physicians, like other frontline health care professionals, continue to experience high levels of burnout, stress, and other mental health challenges, all of which have been exacerbated by the working conditions of the COVID-19 pandemic response, increasing rates of workplace violence, and the growing crisis of emergency department (ED) boarding. We have also witnessed how these issues have deeply affected the talented nursing and emergency medical services (EMS) personnel that are integral to the emergency care team. Despite these many challenges, emergency physicians remain on the frontlines, 24 hours a day, 7 days a week, 365 days a year, to ensure that our patients in need of lifesaving emergency care have access to the health care safety net.

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 217 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.

As we work to ensure continued care for patients across the country, we appreciate the opportunity to share some of the key workforce issues for emergency medicine that also affect the entire health care workforce. 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; protecting emergency physicians, nurses, and staff from violence in the ED; preserving high- quality emergency care; improving access to care for those

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in mental health crisis, providing more pathways to recovery for patients with substance use disorders; and, ensuring fairness and stability in Medicare physician payments through necessary reforms and improvements, among many others.

Emergency Department Boarding, Stress, and Burnout

The emergency department (ED) serves as the “front door” to the health care system, receiving more than 130 million visits per year, with more and more of our patients older in age and arriving via emergency medical services (EMS) transport. 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.

In recent months, hospital EDs have been brought to a breaking point, not from a novel problem, but rather from a decades-long,¹ unresolved problem known as patient “boarding,” where admitted patients are held in the ED when there are no inpatient beds available. **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 psychiatric, skilled nursing, or other specialized 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.

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, and other health care professionals.

As our health care workforce becomes increasingly strained, these patients must stay in the ED for days, weeks, or even months on end waiting for a bed to become available so they can be admitted or transferred. [Ample research](#) supports the conclusion that ED crowding leads to increased cases of mortality related to downstream delays of treatment for both high- and low-acuity patients. Boarding can also lead to ambulance diversion, increased adverse events, preventable medical errors, lower patient satisfaction, violent episodes in the ED, and higher overall health care costs. 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

Reducing boarding and mitigating its effects on all patients is critical in improving patient outcomes and their overall health, especially for those with mental or behavioral health needs. 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. Some research has shown that 75 percent of psychiatric emergency patients, if promptly evaluated and treated in an appropriate location – away from the active and disruptive ED setting – have their symptoms resolve to the point they can be discharged in less than 24 hours, further highlighting the need to provide timely, efficient, and appropriate mental health care.

These severe conditions are contributing to the already staggering rates of burnout among emergency physicians and nurses. Health care professionals experiencing burnout have a much higher tendency to retire early or stop practicing altogether. This increases the loss of experienced, skilled health care professionals in the workforce and adds more strain to those still practicing, which continues the cycle of burnout within the professions.

¹ Andrulis DP, Kellermann A, Hintz EA, Hackman BB, Weslowski VB. Emergency departments and crowding in United States teaching hospitals. *Ann Emerg Med.* 1991 Sep;20(9):980-6. doi: 10.1016/s0196-0644(05)82976-2. PMID: 1877784.

Nursing shortages have exacerbated the deficiency of the health care workforce and stretched care teams to take on extra hours, care for more patients, and shoulder additional clinical and nonclinical duties. Adding to this challenge is the fact that EDs are also not subject to the same staffing ratio requirements as other parts of the hospital often are, and as a result, the ED too often becomes the only place in which to keep many patients. Prior to the pandemic, the American Association of Colleges of Nursing already projected a nursing shortage. That trend has accelerated due to COVID-19, confirmed by a recent American Nurses Foundation survey² which found that 21 percent of nurses surveyed intended to leave their position, with another 29 percent considering leaving. Almost half of all respondents cited insufficient staffing as a factor in their resignation, and their departures will only increase the insufficiency, forcing their fellow nurses to an even more severe condition and impeding the ability to provide high-quality patient care.

Though stress is a given in emergency medicine, the rate of burnout is of tremendous concern and causing additional strain to an already crippled healthcare system. Shift work, scheduling, risk of exposure to infectious disease, and violence in the emergency department can all affect the mental health and wellbeing of the physicians and nurses. Coupled with overcrowding and boarding in the ED, health care professionals are now facing stresses and moral injury that go well beyond everyday practice. The danger of the cycle of burnout is further demonstrated with the American Medical Association (AMA)'s recently released study that shows that 62.8 percent of physicians felt burned out in 2021. The AMA has also highlighted how system-level drivers of burnout, such as increased documentation requirements and other administrative burdens, less efficient workflows and difficulties with electronic health records (EHRs), loss of physician autonomy, and other stresses, are affecting the broader physician community. Additionally, according to another recent study³ in Mayo Clinic Proceedings, the burnout rate among physicians in the United States spiked dramatically during the first two years of the COVID-19 pandemic. It is critical that we end the burnout cycle in EDs to ensure our nation's health care workforce can meet the needs of its patient population.

There is no one-size-fits-all solution to ED boarding, as the needs of each community and each ED often vary significantly. Broadly though, 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. Improving the working conditions of providing patient care not only benefits patients and promotes their well-being, but will also help address some of the significant factors contributing to the mental health and burnout crisis among health care workers.

Among the potential solutions we encourage Congress to consider and implement:

- Create a dashboard of available intensive care unit (ICU) beds across the U.S. for EDs to consult for placing patients. Additionally, Congress should establish and enforce a requirement that hospitals develop contingency plans when inpatient occupancy exceeds 85 percent, including a load balancing plan and an identification and utilization plan of alternative space and staffing for inpatients when greater than 25 percent of ED licensed bed capacity is occupied. There should also be reimbursement incentives for hospital systems to transfer patients outside of their system in limited cases of extreme boarding.
- Enact the "Improving Mental Health Access from the Emergency Department Act" (H.R. 1205/S. 2157 in the 117th 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. H.R. 1205 was passed by the House of Representatives during the 117th but was not considered by the Senate. We anticipate this bill will be reintroduced in the near future and urge the Committee to consider and pass this important legislation.
- Fully repeal the Institutions of Mental Disease (IMD) exclusion so Medicaid beneficiaries can be released from the ED and receive psychiatric inpatient treatment in a more appropriate setting. Though this longstanding policy was intended to reduce the number of people committed to long-term psychiatric treatment facilities without receiving appropriate care, it has perpetuated the problem of disparate treatment of mental health and stands as a major barrier in the effort to provide necessary non-hospital inpatient psychiatric care options. Additionally, simply repealing the IMD exclusion will not by itself expand the number of available beds in a community, so we encourage Congress to incentivize efforts

² [Mental Health and Wellness Survey Report](#). American Nurses Foundation 2021.

³ Tait D. Shanafelt, Colin P. West, Lotte N. Dyrbye, Mickey Trockel, Michael Tutty, Hanhan Wang, Lindsey E. Carlsare, Christine Sinsky, Changes in Burnout and Satisfaction With Work-Life Integration in Physicians During the First 2 Years of the COVID-19 Pandemic, Mayo Clinic Proceedings, 2022, <https://doi.org/10.1016/j.mayocp.2022.09.002>

to help communities establish appropriate mental health care facilities for those who need longer-term psychiatric care, as well as incentives to expand the mental health workforce.

- Prohibit health plans participating in Medicare Advantage (MA) from requiring prior authorization in order to transfer patients from the hospital to a post-acute facility. The presence of prior authorization within MA has resulted in patients staying unnecessarily long in the hospital as they wait for the administrative processes to complete.
- Make permanent the Medicare geographic and originating site waivers for telehealth and maintain existing flexibilities regarding medical screening examinations to reduce buildup of patients presenting to EDs. The Centers for Medicare & Medicaid Services (CMS) should continue to maintain some ED evaluation and management (E/M) codes, observation codes, and critical care codes on the list of approved Medicare telehealth services.
- Support the implementation of alternative care models that aim to improve emergency psychiatric care and reduce psychiatric patient boarding, such as Behavioral Health Emergency Rooms, EmPath units, and Psychiatric Emergency Services (PES) units. Communities throughout the U.S. have successfully implemented these models and can help develop best practices to help establish these models in more communities.
- Create more robust quality metrics that measure ED throughput and boarding. CMS should maintain the ED-2 Admit Decision Time to ED Departure Time for Admitted Patients measure in the Medicare Hospital Inpatient Quality Reporting Program, instead of sunsetting the measure in 2024. This is one of the only measures available to track this statistic and provide incentives and enforcement to help reduce wait times and boarding.

We continue to develop a number of other potential legislative and regulatory solutions and look forward to sharing those with you in the near future.

Additionally, we remain deeply grateful for Congress' bipartisan work, especially in the HELP Committee, 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 important law, named in honor of the life and legacy of our emergency physician colleague Dr. Lorna Breen, provides much-needed resources to promote and improve mental health among the health care professional workforce. However, due to the limited available funds and the large number of grant applications, only a small percentage of the highly rated proposals received were actually funded. We urge Congress to ensure that the critical programs and resources provided under this law are adequately funded to improve the mental health of the health care workforce. Acknowledging this is not HELP Committee jurisdiction, regardless, we urge congressional appropriators to provide \$45 million for the Health Resources and Services Administration (HRSA) Preventing Burnout in the Health Workforce Program for fiscal year 2024.

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.

This issue has profound effects on the health care workforce shortage. 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. These stresses have significantly contributed to attrition among health professions, especially within the nursing workforce. The Emergency Nurses Association notes that workplace violence is "...increasingly seen as a contributing driver of poor nurse retention and recruitment, further exacerbating the nursing shortage and its costly consequences for healthcare organizations and their patients."⁴

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

⁴ Emergency Nurses Association Position Statement: Violence and Its Impact on the Emergency Nurse.
<https://stopedviolence.files.wordpress.com/2019/11/violence-and-its-impact-on-the-en-final-board-draft.pdf>

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.

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.

ACEP supports multi-pronged legislative efforts to address various aspects of health care workplace violence prevention. During the 117th Congress, ACEP supported two bipartisan bills to address workplace violence: the "[Workplace Violence Prevention for Health Care and Social Service Workers Act](#)," (H.R. 1195/S. 4182), introduced by Reps. Joe Courtney (D-CT), Don Bacon (R-NE), and others in the House, and by Sen. Tammy Baldwin (D-WI) in the Senate; as well as the "[Safety From Violence for Healthcare Employees \(SAVE\) Act](#)," (H.R. 7961) introduced by Reps. Madeline Dean (D-PA) and Larry Bucshon (R-IN). The Workplace Violence Prevention for Health Care and Social Service Workers Act would ensure that health care workplaces implement violence prevention plans and techniques and are prepared to respond to acts of violence, while the SAVE Act would establish federal legal penalties for individuals who knowingly and intentionally assault or intimidate health care workers and provide grants to help hospitals and medical facilities establish and improve workplace safety, security, and violence prevention efforts. We are hopeful these bills will be reintroduced as soon as possible and that the Committee will consider these and other efforts to reduce the threat and incidence of violence against emergency physicians and other health care workers.

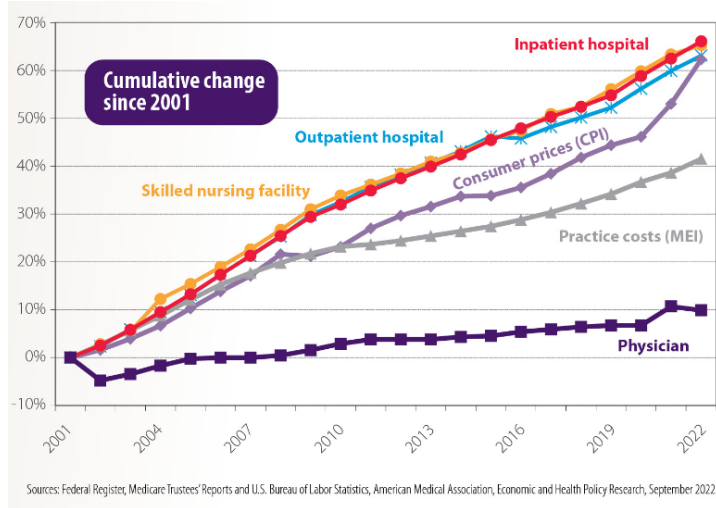
Financial Stability and Economic Prospects

While only a small piece of the workforce puzzle, financial stability and certainty are critical in ensuring the sustainability of the physician workforce. In the 2017 Medscape Physician Compensation Report, 68 percent of emergency physicians reported feeling fairly compensated – the highest among the surveyed specialties. By 2022, only 53 percent reported feeling fairly compensated, as emergency physicians no longer feel that their compensation matches the effort and demands of the specialty.

This has also been exacerbated by the growing corporatization of medicine and diminishing autonomy for individual emergency physicians. This is a significant concern among many physician specialties, but particularly acute for emergency physicians who now have the lowest rates of practice ownership of all the specialties surveyed by the American Medical Association (AMA). Over the last several years, sales of emergency physician practices have accelerated, with large health care systems and private equity firms acquiring physician groups and furthering consolidation within the broader health care system. Additionally, many independent small and mid-sized groups are facing increasing difficulties in negotiating with private insurers. This has been especially pronounced in the wake of the implementation of the No Surprises Act (NSA), as insurers have explicitly cited the NSA in demanding significant rate reductions and threats of contract terminations, and practices have been largely unable to access the independent dispute resolution process established under the law. And on top of all of this, physicians have absorbed cuts in Medicare reimbursements over the last several years as well.

Stability in the Medicare payment system is critical to guarantee 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 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 note that without changes, future access to Medicare-participating physicians will become a significant long-term problem. ACEP strongly agrees with this assessment.



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 the efforts led by Representatives Ami Bera, M.D. (D-CA), Larry Bucshon, M.D. (R-IN), Kim Schrier, M.D. (D-WA), Michael Burgess, M.D. (R-TX), Earl Blumenauer (D-OR), Brad Wenstrup, D.P.M. (R-OH), Bradley Schneider (D-IL), and Mariannette Miller-Meeks, M.D. (R-IA) in September 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.

Preserving High-Quality Emergency Care

As you work to address these challenges, ACEP urges Congress to ensure that American patients have access to high-quality lifesaving emergency care. 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 nurse practitioners (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. 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.

Rural Shortages

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.

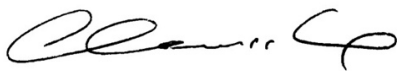
Some have proposed expanding the scope of practice of nonphysician professionals in order to increase access to care, especially in rural and underserved communities. However, in reviewing the actual practice locations of nurse practitioners and primary care physicians, it is clear nurse practitioners 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 health care workforce. We look forward to working with the Committee during the 118th Congress to help ensure that our health care 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,

A handwritten signature in black ink, appearing to read "Chris Kang", written in a cursive style.

Christopher S. Kang, MD, FACEP
ACEP President