American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

February 25, 2025

The Honorable Robert F. Kennedy Jr.
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Kennedy:

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.

As we work to care for our patients, we are eager to partner with the Administration to identify these 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.

We appreciate the opportunity to share with you some of the key priorities for and challenges facing emergency medicine. These include 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; 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 incorporating emergency care in innovative, value-based models.

Boarding

Patient "boarding" occurs when a patient continues to occupy an ED bed while waiting to be admitted to an inpatient bed in the hospital after being seen and treated by a physician, or waiting to be transferred to a 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

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

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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. Boarding has **become a public health emergency**, and a critical component of our nation's security and preparedness is on the verge of breaking beyond repair – with this breaking point 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 or even waiting room chairs not set up for the extra monitoring they need or even waiting room chairs. Though boarding is a multifactorial problem, misaligned incentives in how health care is financed remains a pervasive driver. As hospitals continue to bring in and dedicate beds to elective admissions while boarding the backlog of non-elective patients in the ED, the financial benefits of ED boarding exceed the cost.[2] ACEP has developed a broad range of potential legislative and regulatory solutions that will alleviate the burdens and overall strain on EDs caused by patient boarding, which we would welcome the opportunity to discuss with you.

Emergency Care's Role in Value-based Care to Help Address Chronic Disease Epidemic

ACEP agrees that chronic illness is a growing health crisis. As stated earlier, the ED is the entry point to the health care system for millions of Americans, and therefore, we believe that we play an essential role in helping to address this epidemic. EDs provide a place where those in need of the most immediate attention can receive care, including patients who have delayed or deferred treatment for more minor conditions or symptoms of chronic disease due to barriers in receiving primary care. Such deferral or delay often results in their condition or symptoms becoming exacerbated, and, due to the progression of their condition, their care in the ED will be much costlier and more complex than if they had earlier access to more routine primary care. Thus, ED visits present an opportunity to initiate a coordinated care plan from the most acute medical episode to symptoms of a chronic disease. Payment mechanisms should be put in place so that emergency physicians have the capacity to collaborate with patients to assess and address potential barriers to safe discharge, needs related to care coordination, and additional assistance that may be necessary, such as telehealth or in-person follow-up services.

In order to fill the gap in available emergency medicine alternative payment models (APMs), ACEP developed the emergency medicine-specific Acute Unscheduled Care Model (AUCM).[3] The model would reward emergency physicians for reducing inpatient admissions and observation stays, when appropriate, with emergency physicians becoming key members of the continuum of care, as the model focuses on ensuring follow-up care for emergency patients, minimizing redundant post-ED services, and avoiding costly post-ED discharge safety events.

From the patient perspective, patients would receive better quality and more coordinated care if such a model were implemented. Under the model, a patient who arrived at the ED would be assessed by a clinician to determine if their presenting symptoms are associated with one of the targeted diagnostic categories (as initially designed, for the first two to three years, the model would focus on episodes related to four high-volume ED conditions – abdominal pain, altered mental status, chest pain, and syncope). Concurrent to clinical care, the patient would undergo a safe discharge assessment (SDA) to identify potential barriers to safe discharge, needs related to care coordination, and additional assistance that may be necessary. This interaction is designed to support patient and family engagement and to lay the groundwork for shared decision-making at the time of discharge. The physician would then participate in shared decision-making at the time of discharge and provide discharge instructions to the patient and family. If the emergency physician, in collaboration with the primary care physician or designated specialist, determines that the patient is a candidate for discharge, the information captured during the SDA would be used to generate unique patient discharge instructions including identifying symptoms that would require rapid reassessment and return to the ED.

[2] "Despite CMS Reporting Policies, Emergency Department Boarding Is Still A Big Problem—The Right Quality Measures Can Help Fix It", Health Affairs Forefront, March 29, 2022. DOI: 10.1377/forefront.20220325.151088

[3] More information about the AUCM can be found at: https://www.acep.org/apm.

It is imperative that the coordinated care plan is patient-centered, with shared decision-making at the forefront of post-ED care plans to empower patients to make the best choices for their disease management. Research reveals that patients who are empowered to make health care decisions that reflect their personal preferences often report feeling more engaged in their health care and experience better health outcomes, like decreased anxiety, quicker recovery, and increased compliance with treatment regimens.[4] If patients feel empowered to make choices and comfortable with their care plan, they will be more inclined to comply with the treatment plan to manage their conditions, therefore leading to cost savings in the long run.

The Medicare Access and CHIP Reauthorization Act (MACRA) was designed to transition the U.S. health care system toward value-based care by incentivizing high-quality, cost-effective treatment through APMs like the AUCM. A key component of this transition was the establishment of the Physician-Focused Payment Model Technical Advisory Committee (PTAC), which was tasked with evaluating proposed APMs and making recommendations for their broader implementation. However, CMS' Center for Medicare and Medicaid Innovation (CMMI) has failed thus far to execute this mandate. Despite PTAC's rigorous assessments and approvals of various APMs (including ACEP's AUCM that it highly recommended for adoption), CMMI has been reluctant to scale these models, limiting the intended shift away from fee-for-service and stalling the broader adoption of innovative payment structures. This regulatory inaction undermines MACRA's core goal of fostering a sustainable, value-driven health care system. ACEP would be happy to work with CMS on how to incorporate features of the AUCM into a specialty care model geared towards emergency physicians.

Stopping Bad Insurer Behavior

Whether through abuse of prior authorization procedures, frequent attempts to undermine and erode the federal prudent layperson standard, outright denials of necessary care, or explicit violations of the No Surprises Act (described more below), health insurance companies 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 efforts 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 seen and provided with stabilizing treatment, 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 stricter staffing 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. Downcoding is the practice of arbitrarily assigning a lower billing code to a medical service than what was actually provided. Insurers justify this by claiming that certain emergency department visits were less severe than reported, despite clear medical documentation demonstrating the complexity and acuity of care delivered. This deliberate underpayment not only undervalues the critical, often life-saving care provided by emergency physicians, but also shifts more financial burden onto patients, which contributes to dissatisfaction.

President Trump during his first term signed the landmark No Surprises Act, federal protection to establish critical safeguards to protect patients from out-of-network billing disputes between health care providers and insurers, while

[4] https://www.news-medical.net/news/20170314/Shared-decision-making-leads-to-better-patient-outcomes-higher-satisfaction-rates.aspx

not tilting the carefully crafted independent dispute resolution (IDR) process in favor of either party, as part of the Consolidated Appropriations Act, 2021 (P.L. 116-260). However, in the time since President Trump signed this landmark federal protection into law, its flawed and biased implementation by the Biden Administration has sown confusion among arbiters and regulators as judges have sought to ascertain its meaning.

Insurers have flagrantly gamed this flawed implementation of the law, exploited the regulations to attempt to strong-arm physician groups into accepting drastic cuts to longstanding **in-network** contracts. Bad behavior by health insurance plans and issuers is harming patients, increasing administrative burdens, and driving up health care costs by illegally and improperly exploiting the No Surprises Act's IDR process to avoid complying with the law's requirement to cover emergency medical services.

We urge you to protect patients and reduce avoidable administrative waste and unnecessary costs to the system and the government by implementing the No Surprises Act according to original Congressional intent, and to finalize the long-stalled Federal Independent Dispute Resolution Operations Proposed Rule (88 FR 75744) in order to help improve efficiency and protect consumers.

Partnership

Emergency physicians proudly serve on the frontlines of public health and safety, providing high-quality care to 140 million patients annually, and routinely responding to a wide array of disasters and emergencies. We value coordinating these duties with the numerous federal agencies charged with enhancing the health and well-being of patients in our country. Given the unique role that we play in the health care system, it is vitally important that we have strong partnerships with federal agencies. We stand ready to work collaboratively with HHS to ensure that our emergency departments remain strong and capable of delivering the lifesaving care that Americans need and deserve.

We would appreciate the opportunity to meet with you to discuss how we can support your priorities, particularly your commitment to addressing chronic diseases. If you have any questions and would like to arrange such a meeting, please contact Laura Wooster, ACEP's Associate Executive Director for Advocacy & Practice Affairs at lwooster@acep.org.

Sincerely,

Alison Haddock, MD, FACEP
ACEP President