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American College of
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An Update on **Emergency Medicine**

An ACEP Perspective



L. Anthony Cirillo, MD, FACEP

★ ★ ACEP National President ★ ★

ACEP|EMF Partner Collaborative



July 22, 2026



A Plan to Help Rural EDs

Rural EM physicians face immense challenges in providing comprehensive care with limited resources. Learn how the new bipartisan Rural Hospital Emergency Department Guarantee Act would provide funding to sustain patient care in the latest episode of the Built on Results podcast. ACEP Past President Aisha Terry, MD, MPH, FACEP, discusses what this legislation could mean for EM physicians, rural hospitals, and the patients who rely on them. Stream the full series wherever you listen to podcasts.

Listen Now

FEATURED



Join us in Chicago: ACEP26
Registration is Now Open



Fuel Your Future with ACEP
Accelerate



Built on Results: Explore the impact of
ACEP advocacy



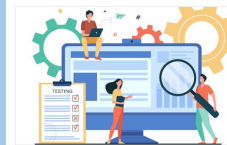
Forging Our Future. 2025 ACEP
Impact Report

Chat now



Chapters are independently incorporated and advocate for the rights of physicians and their patients to ensure the delivery of the highest quality emergency care. Chapters also provide a wide range of activities including educational meetings, networking and social events, leadership development, state legislative lobbying, public relations, and member services.

ACEP has 53 chapters – one in each state plus three additional chapters for Puerto Rico, the District of Columbia, and government services. [Learn more about the relationship between Chapters and ACEP.](#)



Chapter Directory



Chapter Events

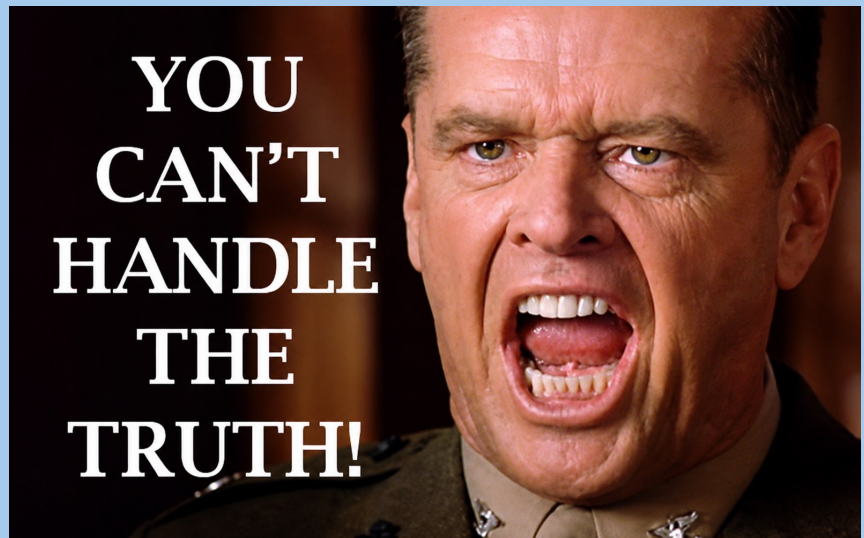


State Advocacy

**Welcome,
to the real
world**



**YOU
CAN'T
HANDLE
THE
TRUTH!**





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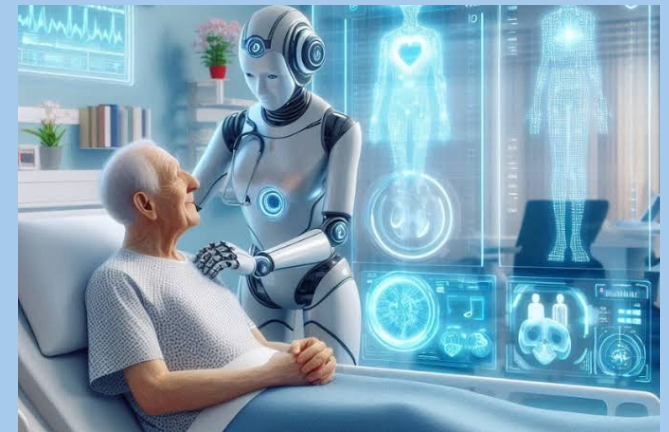


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Nonwearable Single-Time-Point DHT



Pulse oximeter



Blood-pressure cuff



Scale



Glucometer

Continuous or Semicontinuous Wearable DHT



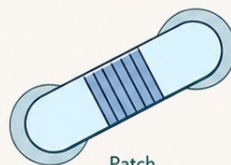
Wrist band



Ring



Chest band



Patch

Connectivity and Data Transmission



Smartphone



Direct cellular
service



Cellular hub



Bluetooth

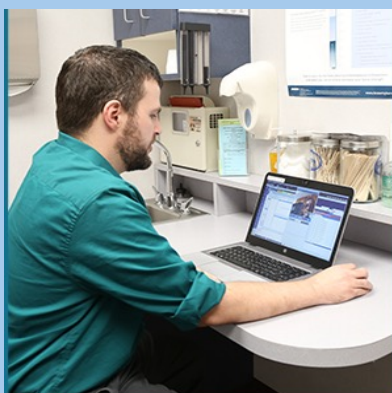
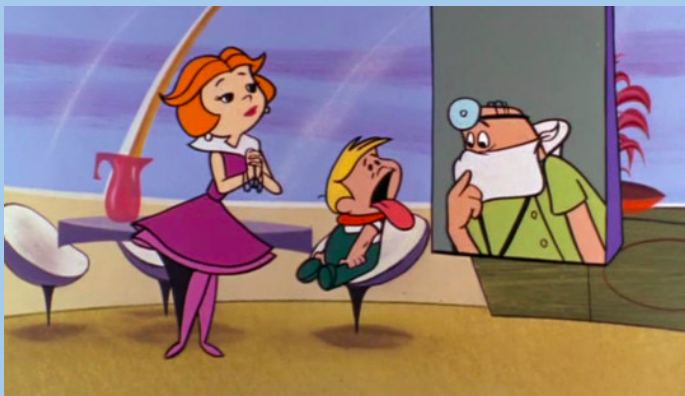


Wifi

Patient-Reported Outcomes

- General and disease-specific symptoms
- Health status
- Medication adherence
- Quality of life
- Outcomes





From the comfort of your home, you can connect with your care provider



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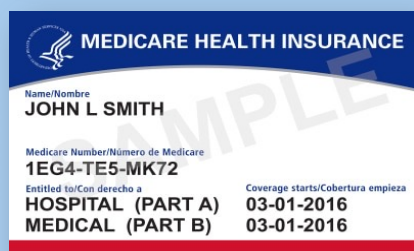
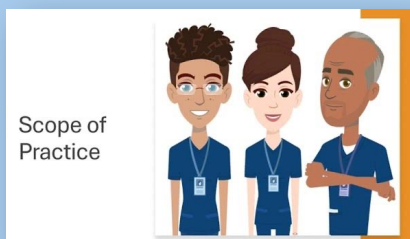


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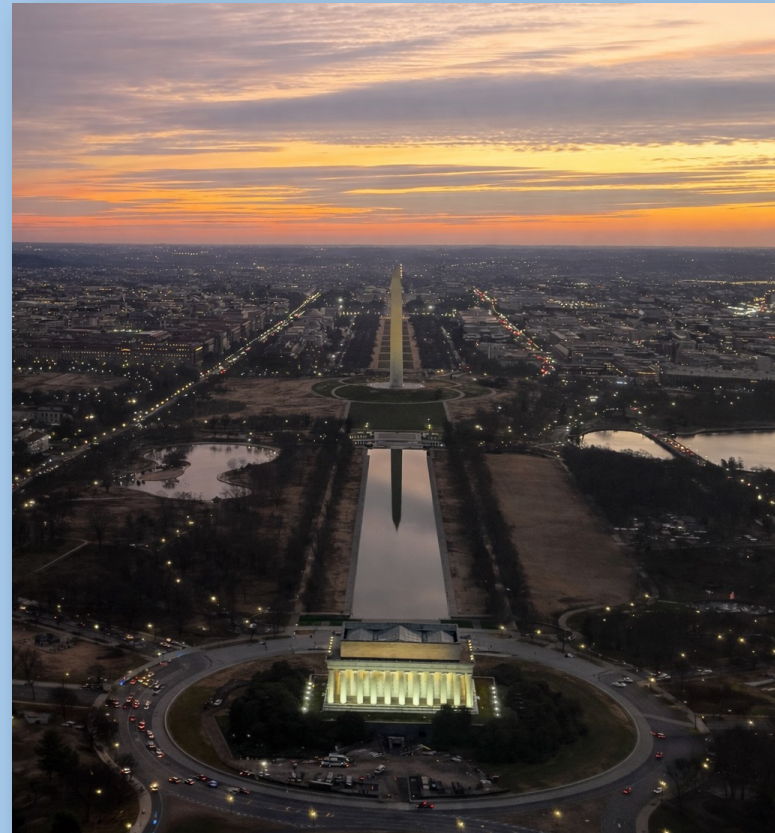
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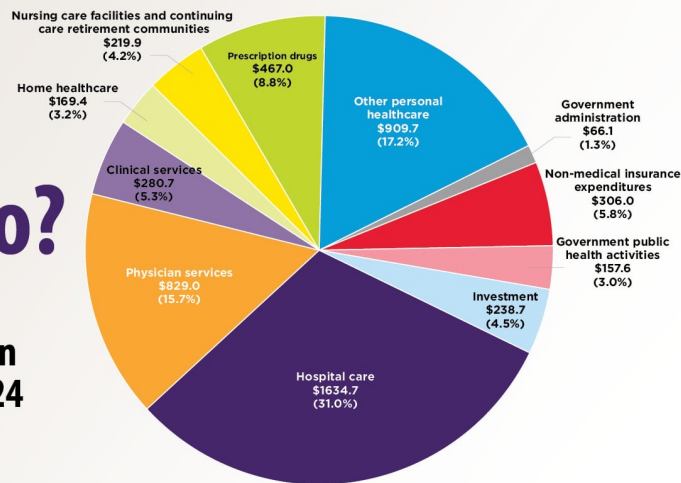






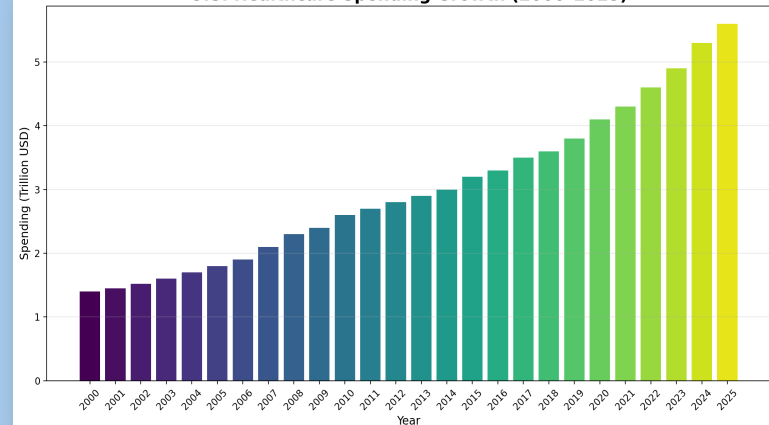
Where did it go?

The U.S. spent \$5,278.6 billion on health care in 2024

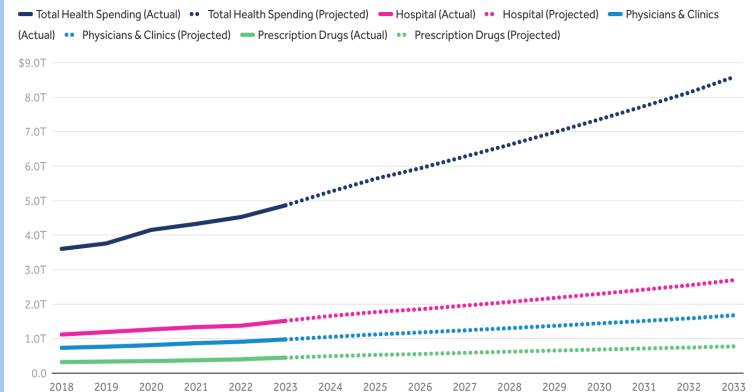


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U.S. Healthcare Spending Growth (2000-2025)



Total health spending, by service type, 2018-2023; projected 2024-2033



Source KFF analysis of National Health Expenditure (NHE) data

Peterson KFF
Health System Tracker

of
ians®



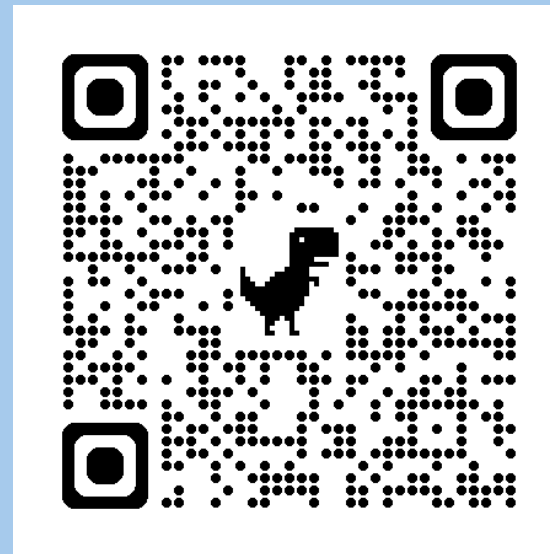
Research Report

MAHSHID ABIR, BRIAN BRISCOMBE, CARL T. BERDAHL, KIRSTIN W. SCOTT, SYDNEY CORTNER,
DANIEL WANG, ROSE KERBER, WILSON NHAM

Strategies for Sustaining Emergency Care in the United States



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CY 2027 Medicare Physician Fee Schedule: What It Means for Emergency Medicine

CMS released its proposed rule for the Calendar Year (CY) 2027 Physician Fee Schedule (PFS) – the annual regulation setting how Medicare pays physicians.

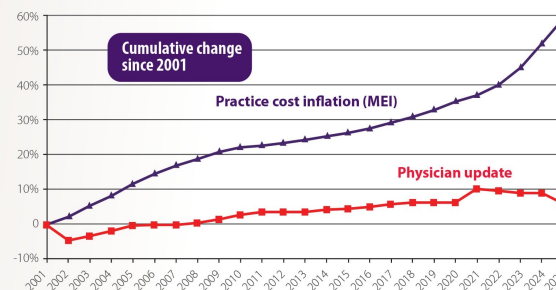
ACEP breaks down everything you need to know as review of the nearly 1,600-page regulation is ongoing.

The bottom line: There is an across-the-board pay cut (1.68%), a significant change to practice expense methodology, and new mandatory quality reporting (MVPs).

Medicare physician payment continues to fall further behind practice cost inflation.

Medicare updates compared to inflation in practice costs (2001–2025)

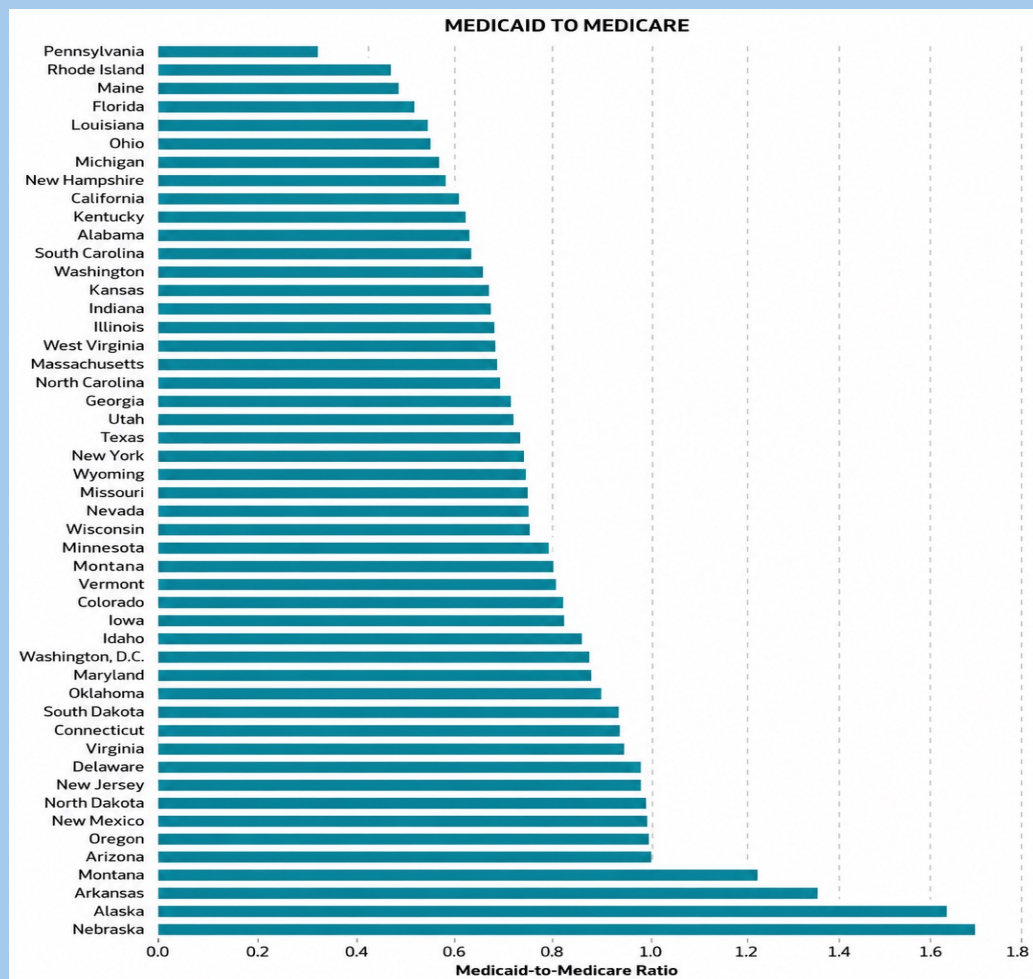
Adjusted for inflation in practice costs, Medicare physician payment **declined 33%** from 2001 to 2025.



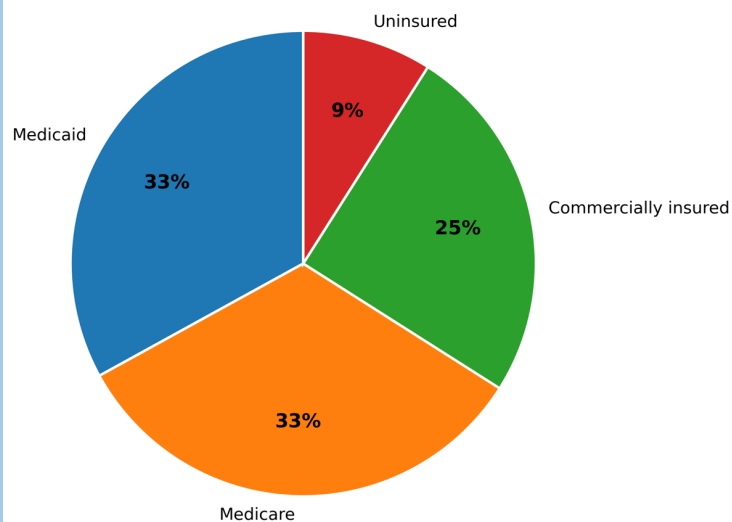
Sources: Federal Register, Medicare Trustees' Reports, Bureau of Labor Statistics, Congressional Budget Office.

Updated Jan. 2025

We need to fix Medicare physician payment NOW.



Emergency Department Patient Payer Mix



“Professional fees (those paid to emergency physicians) have not kept up with inflation, and 20 percent of all U.S. ED physician expected payments went unpaid across all payer types, totaling roughly \$5.9 billion per year of unpaid ED physician services.”

“Uninsured and underinsured patients are more likely to be cared for in the ED, and the sum of all other payments (commercial, Medicare and Medicaid, other) are inadequate to cover the costs of providing care to those populations.”



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Vertical Business Relationships Among Insurers, PBMs, Specialty Pharmacies, and Providers, 2024



2025

FAST FACTS | U.S. Health Systems

WHAT IS A HEALTH CARE SYSTEM? AHA has defined two types of health care systems, and both involve an ownership, lease, sponsorship or contract-management relationship with a central organization. A multihospital system involves two or more hospitals, while a single diversified hospital system involves one hospital and three or more pre- or post-acute health care organizations.

Total U.S. Health Systems = 397

68%

of U.S. hospitals are system-affiliated

77%

of all U.S. hospital beds are system-affiliated

53%

of systems have 1,000 or fewer hospital beds

2%

of systems have 100 or more hospitals



A GLANCE BACK

- In 1940, there were at least 50 systems, all of them Catholic or other nonprofit organizations.
- In 1960, the first investor-owned system was identified.
- In 1990, the AHA conducted a survey identifying 229 systems.

Source: AHA Annual Survey Databases, 7/2020
The figure with the 2007, 2009,



219 Number of systems with 1-5 hospitals

6 Number of systems 100 or more hospitals

210 Number of systems with 1,000 or hospi.



Total U.S. hospitals 6,093

Total U.S. hospitals in systems 4,157

Systems range in size from:

- 1-157 hospitals
- 34-39,457 beds



Total U.S. hospital beds 913,136

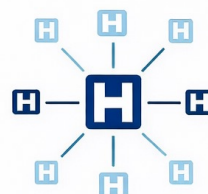
Total U.S. hospital beds in systems 703,731

SOURCE: AHA Annual Survey Databases, 7/2020 | www.aha.org | © 2015 American Hospital Association
To learn more information or purchase access to AHA data | aha.angtabla@aha.org



Fast Facts on U.S. Hospitals, 2024

Two-thirds of Community Hospitals are System-affiliated



68%
System-affiliated
(3,510)



32%
Independent
(1,619)

Community Hospitals by System-affiliated vs Independent (Total 5,129), FY 2022

Source: American Hospital Association. Fast Facts on U.S. Hospitals, 2024

<https://www.aha.org/statistics/fast-facts-us-hospitals>

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J. Warren Salmon
Stephen L. Thompson

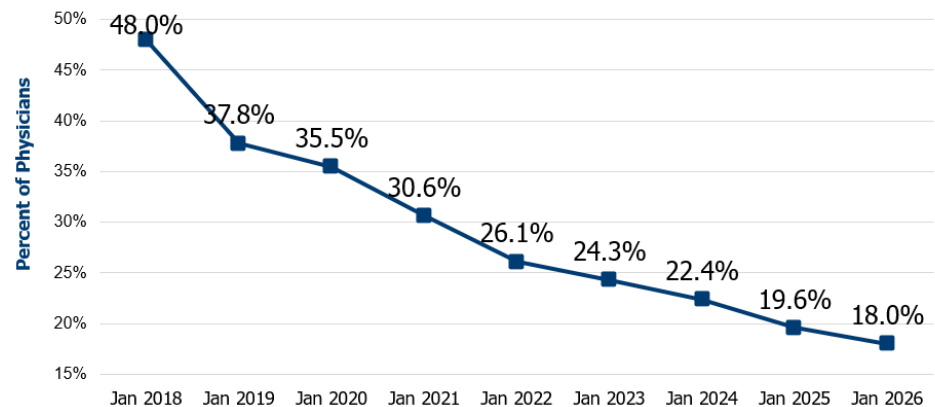
The Corporatization of American Health Care

The Rise of Corporate Hegemony and
the Loss of Professional Autonomy

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18% of Physicians Practice in Physician-Owned Settings in 2026

**PERCENT OF U.S. PHYSICIANS PRACTICING IN
PHYSICIAN OWNED PRACTICES IN 2018-26**



- **18.0%** of physicians were operating independently by January 2026, with a steady decrease from 2019-2026 after a sharp drop in 2018 and **19.5%** decrease in the last two years.

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What Are the Most Common Causes of Physician Burnout?

While physician burnout often affects front-line specialties, its primary causes are present to some degree in nearly all medical practices.



Loss of autonomy
or too much
micromanaging



Excessive focus
on data over
patient care



Too many government,
insurance, and hospital
rules



More punishments
than rewards



Sense of
powerlessness



Complicated
electronic health
records

**MARCUS
WELBY, M.D.**



**JAMES
BROLIN**
as Steven Kiley, M.D.



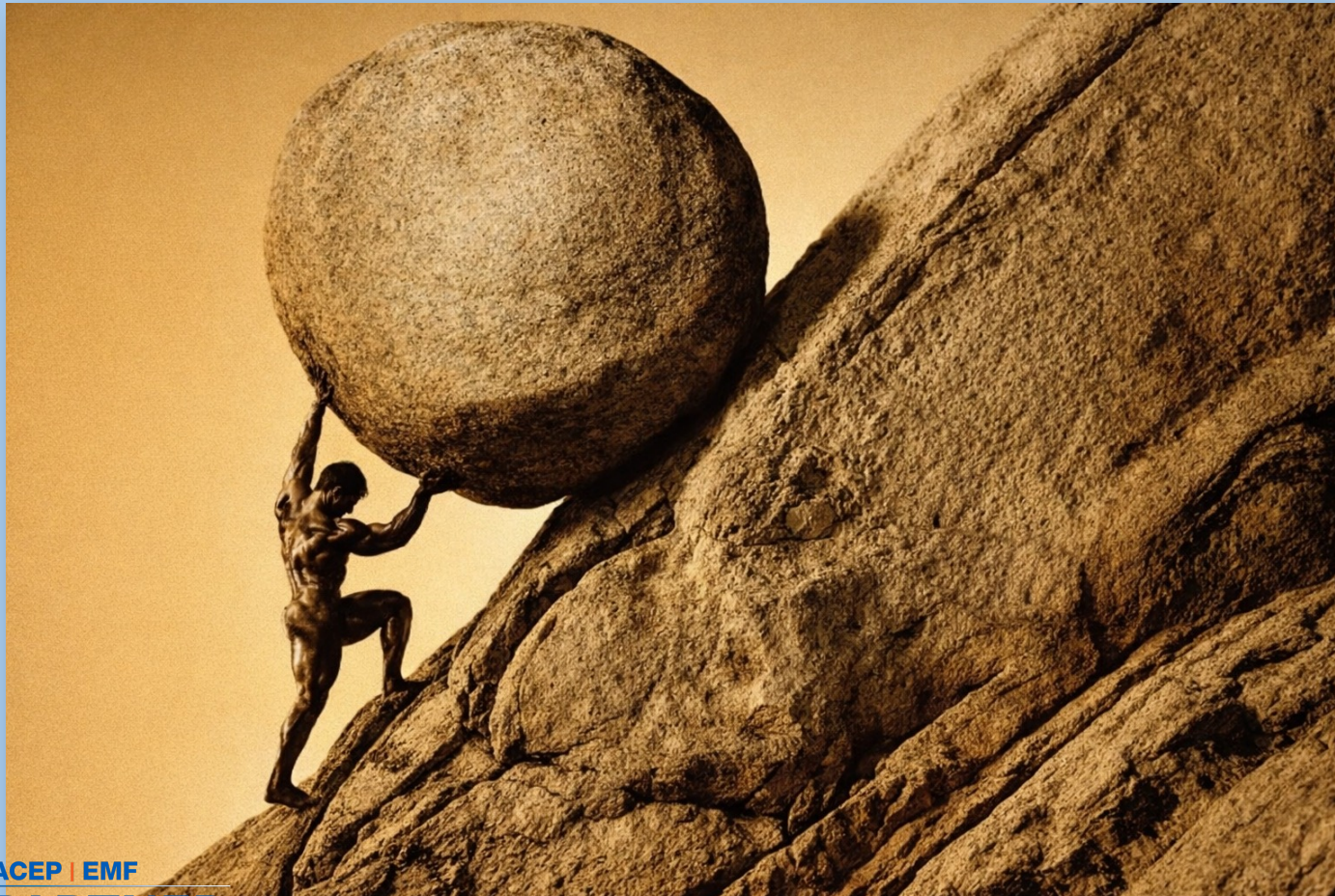
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 **Unhappy =**

 **Expectations** –  **Reality** 



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Feelawonderful™

Feel Happy & Calm Every Day!



- ✓ 😊 Elevates Mood
- ✓ ❤️ Reduces Stress & Worries
- ✓ ✓ Supports Relaxation & Well-Being

Ask Your Doctor About
Feelawonderful

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FIGHT

because your FUTURE
is worth it



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3R's

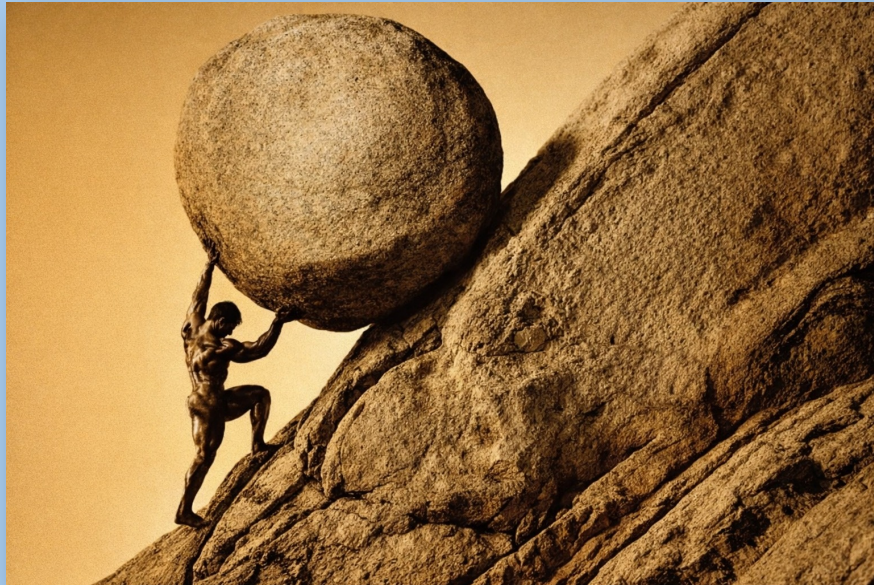
RESPECT

RESOURCES

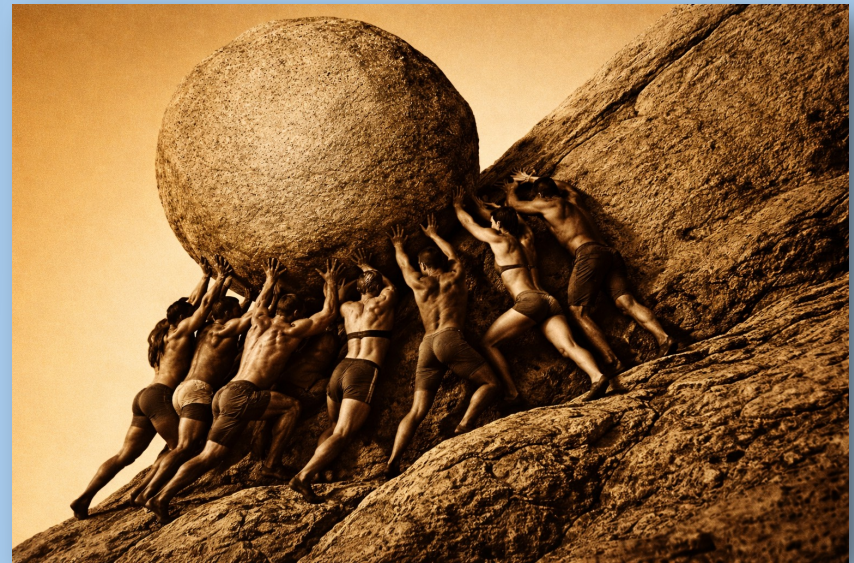
REIMBURSEMENT

“*Advocacy
is the antidote
to apathy...*”





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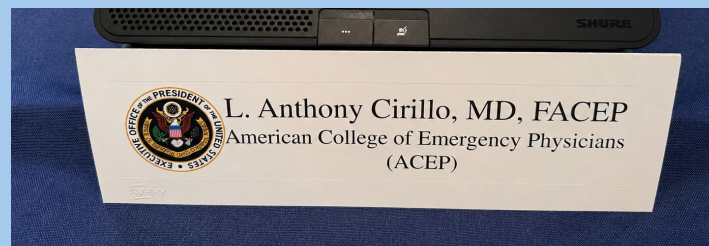
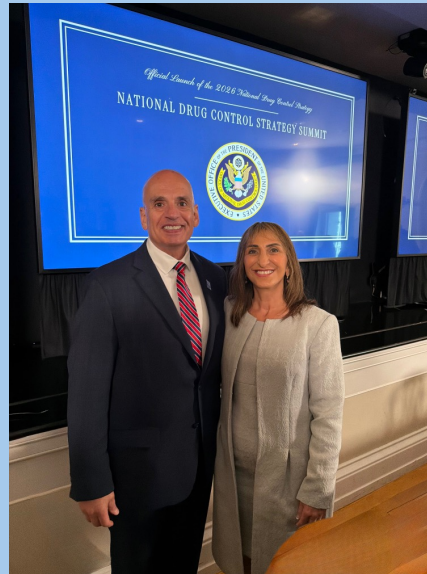
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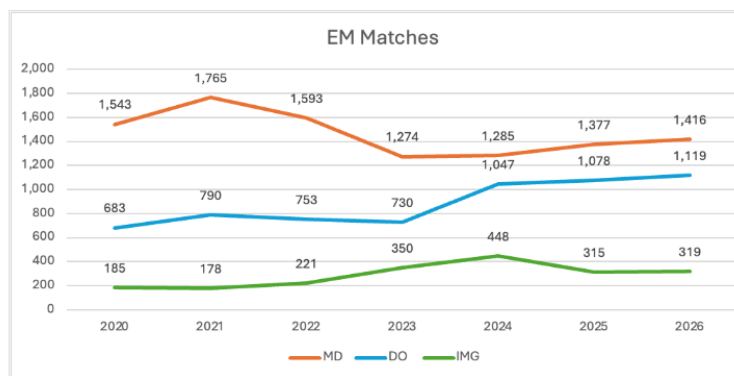


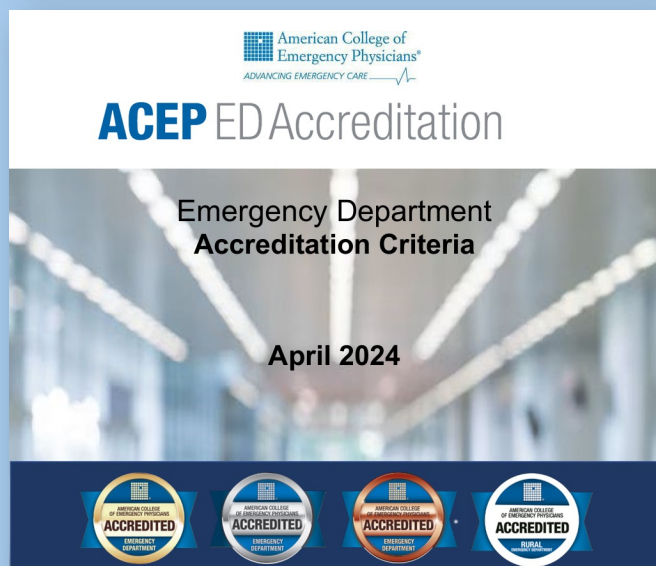
Match Day 2026: EM Reaches All-Time High in Positions Filled

The rebound from the pandemic era continues with 3,058 positions filled. More people have matched into emergency medicine than ever before.

Data shared today from the [NRMP](#) shows 303 programs (11 new programs), 3,196 spots (130 new spots) and 3,058 of 3,098 positions filled (a 95.6% fill rate).

	Applicants	Programs	EM Positions Offered	Positions Filled	Unfilled Positions	% Filled	% unfilled
2020	3751	256	2,655	2,642	13	99.5%	0.5%
2021	4320	273	2,840	2,826	14	99.5%	0.5%
2022	3610	277	2,921	2,702	219	92.5%	7.5%
2023	3218	287	3,010	2,456	554	81.6%	18.4%
2024	4413	292	3,026	2,891	135	95.5%	4.5%
2025	3753	292	3,068	3,003	65	97.9%	2.1%
2026	3616	303	3,198	3,058	140	95.6%	4.4%





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ACEP policies used as the basis for criteria include:

- **Responsibility for Admitted Patients**
- **Disaster Planning and Response**
- **Adult Psychiatric Emergencies**
- **Pediatric Medication Safety in the Emergency Department**
- **Food And Drink for Staff in the Emergency Department**
- **Protection From Violence in the Emergency Department**
- **Pediatric Readiness Guidelines**

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BLUE RIBBON RECOGNITION



The following additional components are not required for accreditation but worthy of acknowledgment because of the hospitals or the emergency medicine staffing model's commitment to physician staff are ensured:

- Due process for emergency physicians regardless of employment/contractual arrangements.
- Contracts with the EPs, including both hospital and contracting group, do not include a restrictive covenant (non-compete).
- Medical staff credentialing and privileging forms do not include questions regarding prior psychiatric care, unless impacting work performance.
- Emergency physicians have the right to view itemized reports of what is billed and collected for their service at least semi-annually.



Address the Emergency Department Boarding Crisis

Emergency patients can face dangerous delays, waiting hours or days for care after being admitted for inpatient care because hospitals lack inpatient beds or transfer options. This dangerous bottleneck, known as boarding, overwhelms emergency departments and puts lives at risk.

How Can Congress Help?

Support the **Addressing Boarding and Crowding in the Emergency Department (ABC-ED) Act (H.R. 2936 / S. 1974)**, a bipartisan bill to reduce boarding and improve outcomes by strengthening data sharing, coordination, and accountability.

Resources:

- [Support the ABC-ED Act \(PDF\)](#)



Protect the Emergency Medicine Workforce

Corporate overreach, a lack of basic employment protections, and violence in emergency departments are driving emergency physicians out of the workforce, putting patient lives and physician careers at risk.

How Can Congress Help?

- Cosponsor the **Bipartisan Workforce Mobility Act (S. 2031)** to ban non-compete clauses in employment contracts and ensure emergency physicians can practice where they are needed most.
- Cosponsor **The Save Healthcare Workers Act (H.R. 3178/S. 1600)** to establish federal criminal penalties for violence against health care workers.
- Cosponsor **The Physician and Patient Safety Act (H.R. 3413/S. 1767)** to ensure emergency physicians have the same due process rights as other specialists.

Resources:

- [Restoring Autonomy and Safety in the Emergency Department \(PDF\)](#)





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POLICY STATEMENT

Approved January 2026

Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department

Revised January 2026,
October 2024, June 2023,
March 2022, June 2020 with
current title, June 2013 titled
"Guidelines Regarding the
Role of Physician Assistants
and Advanced Practice
Registered Nurses in the
Emergency Department"

Originally approved January
2007 titled "Guidelines
Regarding the Role of
Physician Assistants and
Nurse Practitioners in the
Emergency Department",
replacing "Guidelines on the
Role of Physician Assistants
in Emergency Departments"
(2002) and "Guidelines on the
Role of Nurse Practitioners"
in the Emergency
Department" (2000)

Physician assistants (PAs) and nurse practitioners (NPs) serve as integral and valued members of the physician-led emergency department care team. They do not possess the training and expertise in emergency medicine that may only be acquired through successful completion of an ACGME accredited emergency medicine residency training program - there are no exceptions. The American College of Emergency Physicians (ACEP) believes that regardless of where a patient lives, all patients who present to emergency departments (EDs) deserve to have access to high quality, patient-centric care delivered by emergency physician-led care teams. Accordingly, ACEP endorses the following principles for EDs that utilize PAs and/or NPs in the delivery of emergency department care.

Emergency Department Physician-Led Care Teams

- Because of the nature of emergency medicine, in which patients present with a broad spectrum of acute, undifferentiated illness and injury, including critical life-threatening conditions, the gold standard for emergency department care is that provided by an emergency physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) in emergency medicine or pediatric emergency medicine or an equivalent international certifying body recognized by ABEM or AOBEM in emergency medicine or pediatric emergency medicine.
- EDs should have a medical director who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) in emergency medicine or pediatric emergency medicine or an equivalent international certifying body recognized by ABEM or AOBEM in emergency medicine or pediatric emergency medicine.

scope of
practice.



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Preserve Medicare's Promise

Years of Medicare payment cuts are shrinking emergency department capacity and threatening patient access to care throughout the health care system. Congress can provide short-term relief and long-term stability for the Medicare physician payment system to ensure Medicare can fulfill its promise to seniors.

How Can Congress Help?

- Stop the impending Medicare Physician Fee Schedule (PFS) conversion factor cut for 2027.
- Establish a permanent inflationary update to Medicare physician payments.
- Modernize and update PFS “budget neutrality” requirements.
- Update the MACRA framework to reduce physician burdens and facilitate the transition to value-based care.

Resources:

- [Protecting & Preserving Medicare's Promise \(PDF\)](#)



< Latest News



May 6, 2026

PeaceHealth Agrees to Extend Services with Eugene Emergency Physicians

The American College of Emergency Physicians is aware of the announcement that PeaceHealth has reconsidered its contractual agreement with EEP.

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What are you looking for?

Topics Practice Education Advocacy About ACEP

< Latest News

May 14, 2026

Behind the Work to Get Dr. Bolivar Barrios Home

By Bryan Dunn, MD, FACEP, President, Texas College of Emergency Physicians (TCEP)
Jill Sutton, CMP, Executive Director, TCEP

LETTERS

Big Payouts for Some Doctors, Not Others

TO THE EDITOR:

Re "Health Law Lets Doctors Cash In" (front page, April 26), about how a new arbitration system under a consumer protection law has led to large payouts to doctors:

I am confused. In what universe is it normal for a dispute about a fee to be arbitrated so that one party ends up getting hundreds of times the amount that he or she asked for in the first place?

If a doctor sends a bill for what he or she feels is a fair amount and the insurance company comes back with a much lower figure, arbitration can be effective in determining what is fair. If I charge \$500 for a procedure and the insurance company wants to pay me \$150, there is room for arbitration. But for the arbitrator to then award thousands more to the doctor than he said his services were worth is incomprehensible.

As a member of the profession, I am ashamed that physicians would participate in this type of immoral gouging. Small wonder that doctors are losing the position of respect that we enjoyed for generations.

N. DONALD DIEBEL
WINTER PARK, FLA.
The writer is a retired obstetrician-gynecologist.

TO THE EDITOR:

Focusing on outliers dangerously misrepresents the real

threat facing patients: a nationwide practice of insurer underpayment that is destabilizing our emergency medicine safety net.

Emergency medicine accounts for over a third of all arbitration cases — more than any other specialty — because insurers consistently underpay for unplanned care. The No Surprises Act protects patients from surprise medical bills, but insurer practices threaten access to care.

Emergency physicians' high win rate in arbitration isn't evidence of gaming the system; it's proof of systemic underpayment. Professional, neutral arbitrators repeatedly determine that insurers' payments are insufficient. Yet even after losing more than 85 percent of the time, insurers then fail to pay nearly 60 percent of arbitration awards within statutory time frames. These costly delays push our emergency medicine system to a breaking point, risking longer wait times and closures.

The real story is that an insurance industry is profiting by underpaying for care. Congress must pass the No Surprises Enforcement Act to impose meaningful penalties for nonpayment and protect the financial viability of emergency care for all Americans.

L. ANTHONY CIRILLO
SAUNDERSTOWN, R.I.

The writer is the president of the American College of Emergency Physicians.

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Perspectives > Second Opinions

The Case Against Calling It 'Emergency Medicine'

— The misnomer legitimizes overutilization and may be causing harm

by Stephen P. Wood, DMSc, ACNP-BC

June 6, 2016 · 4 min read [Add MedPage Today on Google](#)



Perspectives > Second Opinions

ACEP President: Emergency Medicine Is Here to Stay

— Claims that EDs are too costly and overused miss the mark

by L. Anthony Cirillo, MD

June 25, 2016 · 3 min read [Add MedPage Today on Google](#)



February 2, 2026



ACEP Will Not Endorse New Sepsis Guidelines from the Surviving Sepsis Campaign

After a thorough and comprehensive review by a panel of experts convened from the membership of the College, the American College of Emergency Physicians (ACEP) today informed the Surviving Sepsis Campaign (SSC) that ACEP will not endorse the organization's latest update to guidelines for treatment of sepsis in emergency departments.

The decision to not endorse the guidelines was based on concerns about conflicting guidelines for the treatment of adult and pediatric patients, and a belief that the guidelines developed do not fully reflect the most up-to-date and reality-based approach to the care of all patients in the emergency department, including those with sepsis.

In addition, ACEP also remains deeply concerned that the absence of emergency physician organizational involvement in the governance structure of the Surviving Sepsis Campaign serves to limit the perspectives offered by practicing emergency physicians in the United States when guidelines are being developed.



February 11, 2026



ACEP/EMRA Statement on ACGME's Emergency Medicine Program Length Decision

The American College of Emergency Physicians (ACEP) and the Emergency Medicine Residents' Association (EMRA) support the decision by the Accreditation Council for Graduate Medical Education (ACGME) to defer the decision on changes to the training requirements for ACGME-accredited emergency medicine (EM) residencies.

During this process, the EM community shared voices and perspectives on the fundamental issues of training length and educational experiences. Throughout this time of uncertainty and debate, ACEP and EMRA remain focused on ensuring emergency medicine residents have the educational resources, advocacy, and professional support necessary to deliver outstanding patient care and to thrive throughout training and beyond. Our shared goal is unchanged: to ensure that emergency medicine training, regardless of program length, produces superb, practice-ready physicians and strengthens the future of our specialty. ACEP and EMRA believe that residency training requirements must be based upon foundationally sound, evidence-based data. The future of our specialty and those who are considering EM as a career demand that of us.

EMRA and ACEP have been clear in our support of both three- and four-year EM residency programs, an evidence-based position grounded in our commitment to physician workforce stability, educational excellence, and patient-centered outcomes. We agree that training standards can be raised without mandating increased training time.

In its announcement, the ACGME stated that a new process is being identified to collect additional information and continue the review of training standards, including the length of training. EMRA and ACEP strongly advocate for direct, broad stakeholder involvement throughout this process. Any new review process must be transparent and evidence based. EMRA and ACEP believe all feedback offered to date should remain under consideration moving forward.

ACEP and EMRA are ready to collaborate with the rest of the EM community to ensure the decisions made are the right ones for residency training, our patients, and the future of EM.



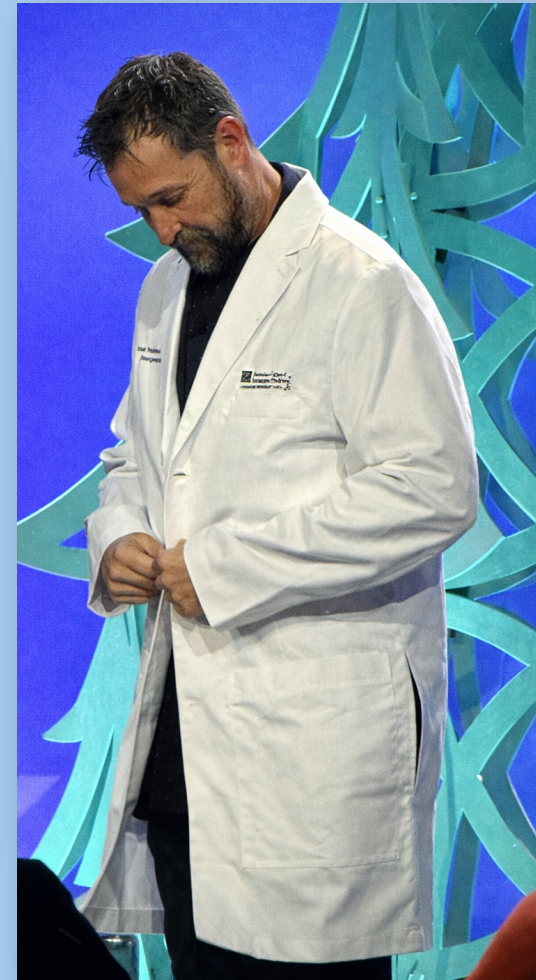
Accreditation Council for
Graduate Medical Education

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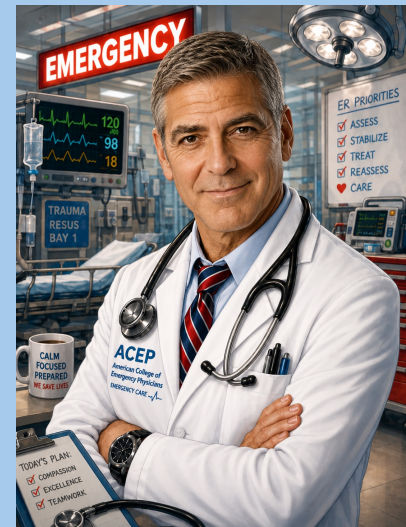
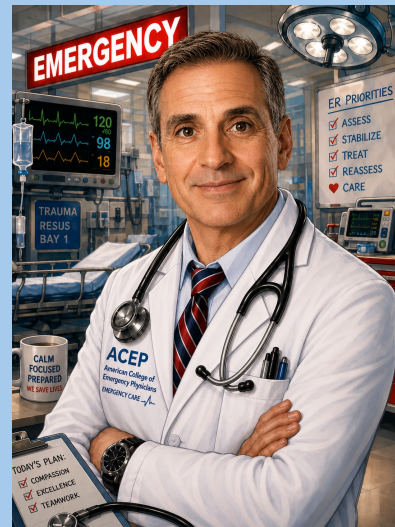
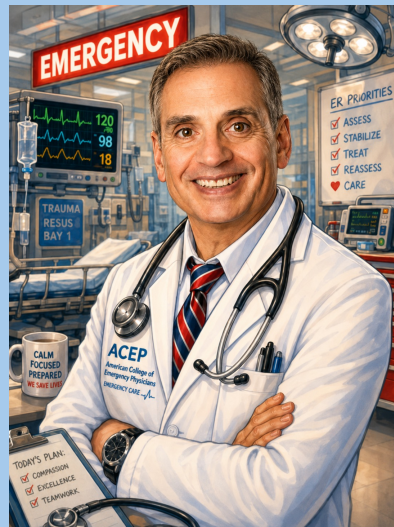
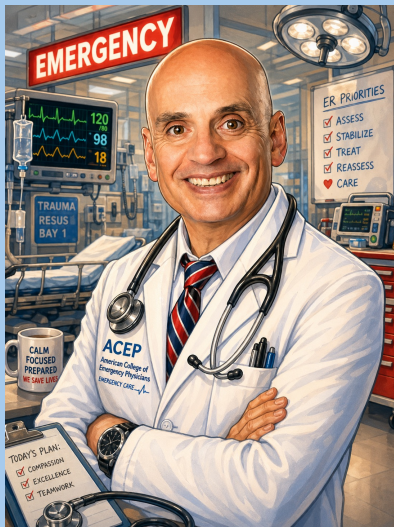
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THANK YOU!

Tony Cirillo

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401-465-0806



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ACEP in the Year Ahead

Building a Strong Future for Emergency Medicine Physicians

Michael Fraser, PhD MS CAE · Executive Director · July 2026



Our Purpose

Advancing emergency care as the voice, advocate, and leader for the specialty of emergency medicine and the physicians who practice it.

ACEP's Value Proposition

Shifting from "here's what we have" to "here's what we help you do" and taking a more focused, member-centered approach to our work.

An investment in ACEP is an investment in you, and in your specialty

Our Strategic Evolution

Building for the members we will have in ten years, not just the ones we have today.

The Opportunity to Partner with ACEP

New ways to learn, grow, and engage alongside ACEP's members across every stage of a physician's career.



2027 is a build year, met with disciplined optimism

What we know about the medial societies of the future:

**Associations that stand still decline;
those that solve real problems thrive.**

FY27 is about stabilizing ACEP but not standing still.

We are modernizing systems, tightening finances, and sharpening strategic focus for the decade ahead while supporting innovation and growth in key areas.

FY26 Financial Milestone	Status
Clean FY25 audit & Form 990 filed	✓ Complete
Debt eliminated - \$1.69M HQ mortgage paid off	✓ Complete
Balanced FY27 budget approved to help stabilize our financial base	✓ Complete

FY27 is about focusing on our priorities and evolving our program capabilities

Five Strategy Priorities for 2027

1 · Advocacy

Fighting for the specialty from the workplace to Washington.

2 · Clinical Excellence

Setting standards, accreditation, and the science of EM.

3 · Practice Innovation

Preparing physicians to lead in evolving care models.

4 · Career Fulfillment

Well-being, workforce, and a sustainable specialty.

5 · Member Engagement

A connected, vibrant community of ACEP members.



Advocacy Wins That Move the Whole Specialty

→ ED Boarding

ACEP's Emergency Care Access and Timeliness electronic clinical quality measure is the ED boarding measure finalized into CMS CY2026 hospital quality rule and the first federal reporting foothold on this critical issue.

→ No Surprises Act

Final IDR rule cut arbitration fees 85%+ (from \$115 to \$15). ACEP's response ran in the *Washington Post*. Working on NSA Enforcement Act PR and research campaigns now

→ Workforce

Pushed back on HRSA's "surplus" of EM physicians research and ACEP is now HRSA's ongoing EM workforce data partner.

→ Residency Training

ACGME paused plans for a mandatory 4-year residency format and will be meeting with stakeholders before issuing final guidance, including at SA26.

→ Rural Hospital Sustainability

ACEP supported bipartisan bill Senators Hawley and Hassan have introduced that expands support for rural emergency departments and access to emergency care.

→ Federal Funding Wins

Lorna Breen Act renewed through FY2030; Telehealth extended; Medicaid DSH cuts blocked and several others

Building Tomorrow's Value: Our Growth Engines



Accreditation Engine

Grow our geriatric, ultrasound, pain/addiction care and ED accreditation portfolio scaling in the U.S. and abroad.



Innovation Zone at SA26

Dedicated exhibit-floor stage in Chicago bringing partners and members together at Scientific Assembly 2026. Planning SA27 now.



AI, On Our Terms

Partnerships to embed ACEP clinical policies into tools physicians use daily; developing a AI verification & validation concept; educational series



EM Innovation Hub

Discussions underway with the EM Innovation Collaborative on an innovation "Center" and physician-led ventures.



ACEP Anytime

Shifting from one annual event to year-round, 24/7/365 continuous education for members everywhere, anytime.



Data and Quality Tools

Evolving CEDR and our quality data to develop new tools for actionable quality insight and performance improvement

Why All This Matters

Associations that embrace innovation are far more likely to experience growth and stronger renewals.

Millennials now represent a growing share of membership at roughly 25%, a presence that correlates positively with organizational health and sustainability.¹

¹ MGI 2026 Membership Benchmarking Report.

ACEP's Membership Engagement Is Strong and Growing

38,216

Total Members

First positive growth since September 2025 and momentum is building.

82.1%

Retention Rate

Rising and climbing toward an 83% target which is the highest in recent years.

ACEP is also reimagining the EMRA-to-ACEP pipeline to retain more emergency medicine physicians post-residency and build long-term relationships starting from day one of training.

Vision 2030: Seven Streams to Deepen Member Relationships

FY27 moves membership from a transaction to a relationship giving EM physicians more reasons to join, stay, and engage.

ACEP Anytime

Continuous learning so you stay current

New Credentials & Recognition

Demonstrate expertise and focus in area of professional development

Personalized Offerings

We know you, and what you might like next

Ongoing Engagement Opportunities

Year-round connection culminating at in-person events

ACEP as a Thought Leader

Positioning ACEP and its partners as experts in EM

Expanding Our Reach

Creating broader audience for EM and the work of ACEP

Building New Ways of Engaging with Industry and EM Partners - What is New, Now, and Next?

Strategic partnerships that fuel innovation and help EM physicians practice with tools & services they helped inform.

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A Platform to Build On

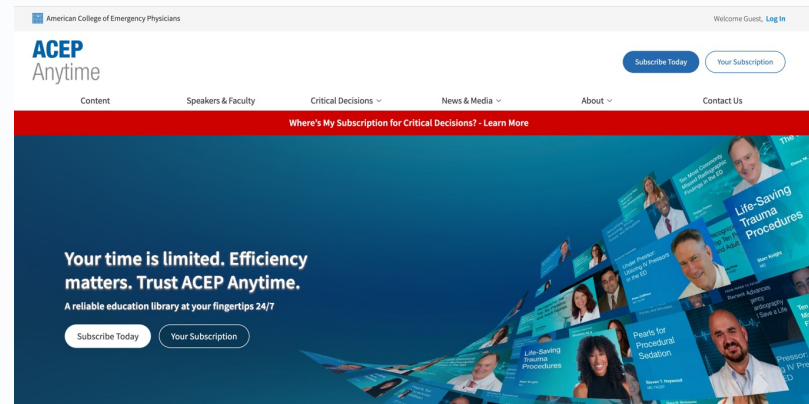
As ACEP shifts to year-round engagement, our sponsorship opportunities evolve from a booth once a year at SA to sustained investment in the programs shaping the future of emergency medicine.

Partners gain access to the most engaged emergency physician community in the world, across digital channels, live events, education, and advocacy, 365 days a year.



The Innovation Zone at SA26 in Chicago is a dedicated partner stage on the exhibit floor — a new kind of engagement opportunity built for this moment.

We will have more like it in 2027 at an emXPO that we are developing in real time now



Metric	Value
Emergency physicians	38,000+
Contacts in database	200,000+
Scientific Assembly	Chicago, Oct 2026
New partner stage	Innovation Zone at SA26 emXPO 2027 in Boston

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Stronger Today. Building for Our Future.

Our Purpose: Advancing emergency care as the voice, advocate, and leader for the specialty of emergency medicine and the physicians who practice it.

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research → education → patient care

Your Partner in Research



Jon Mark Hirshon, MD, MPH, PhD, FACEP
Chair, EMF Board of Trustees





WHO WE ARE

- Mission: Advancing emergency medicine through research and education
- Founded in 1972
- Over \$22 million in funded research
- In 2026/27 EMF is funding over \$900K in research with the help of our donors and partners
- 700+ grantees have benefited



WHY EMF MATTERS

- Drives Evidence-Based Practice
- Pattern Recognition
- Addresses Real-World Challenges
- Amplifies Impact Through Strategic Partnerships



CURRENT RESEARCH FOCUS AREAS

Workforce & Wellness

Health Equity & Access

Clinical Innovation

Public Health & Policy Impact



DIRECTED RESEARCH PAST

PARTNERS





THE IMPORTANCE OF PARTNER SUPPORT

Fisher & Paykel Healthcare

Directed Research in Action

A Partnership Model

- Shared identification of research priorities
- Collaborative development of the funding opportunity
- Partner feedback during Request for Proposal design
- Independent scientific peer review
- Funding research with real-world clinical impact



GET INVOLVED TODAY

Partner with EMF in our Research Grants

Support the Mission through Charitable Support

Connect with our Team

Michelle Parker – Executive Director

Cynthia Singh – Deputy Executive Director

Tony Vellucci – Associate Executive Director



QUESTIONS



email our staff to explore ways to shape the future of Emergency Medicine

**START A CONVERSATION WITH
EMF**

ACEP Legislative and Federal Advocacy Update

Bing Pao, MD, FACEP, ACEP Board of Directors

Ryan Mc Bride, ACEP Senior Director Federal Government Affairs



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2026-2027 *Strategic Priorities*

Advocacy



Champion Policies to Protect Emergency Medicine

Clinical Excellence, Research & Scholarship



Advance Quality, Research, and Education

Practice Innovation



Drive Solutions to Improve Patient Care

Career Fulfillment



*Support Physician Well-Being
& Growth*

Member Engagement & Trust



Build a Stronger, Connected Community

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Federal Advocacy Priorities*

Key policy areas for advancing emergency medicine and patient safety across the nation.



Tier I

- Reduce ED boarding and crowding
- Prevent violence against ED teams
- Strengthen and protect EM workforce (scope, due process, burnout, physician autonomy, bans on noncompete clauses)
- Protect fair payment for ED care (fee schedule, Medicaid, pursue national security funding, etc)
- Stop abusive insurer practices such as downcoding, NSA evasion, prudent layperson violations
- Defend EMTALA; enact liability shields for EMTALA care; and, pursue strategies for accounting/tax considerations for EMTALA-related care



Tier II

- Ensure deductibles are collected from insurers and shift deductible collection to insurers
- Improve rural access to ED care
- Preserve and strengthen ACA coverage
- Ensure full access to evidence-based care for pregnancy-related emergencies
- Advance innovative ED care/payment models
- Strengthen trauma and prehospital systems
- Reduce firearm injury and violence with evidence-based policy
- Expand effective ED substance use care
- Shape HIT, interoperability, and eCQM policy, to improve EM registries and prevent data blocking burdens on EPs



Tier III

- Track proposals to expand insurance coverage programs
- Support advance care planning
- Repeal Medicaid IMD exclusion
- Support interoperable, interstate PDMPs
- Promote affordable meds for ED patients
- Address drug shortages affecting ED care
- Promote comprehensive violence prevention and intervention initiatives
- Support anti-human trafficking protections
- Create National Bureau for Firearm Injury Prevention

*Key areas where ACEP is currently focusing its advocacy efforts and resources; not intended to be an exhaustive list.

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Emergency Department Boarding and Crowding



ALL OF

“Boarding” in the emergency department is a result of dangerous health system overload that puts patients in a holding pattern as the

Causes ER Gridlock: Trapped inpatient boarders block beds, forcing new arrivals into hallways and waiting rooms.

Worsens Patient Outcomes: Extended stays in chaotic ERs increase medication delays, medical errors, and patient mortality.

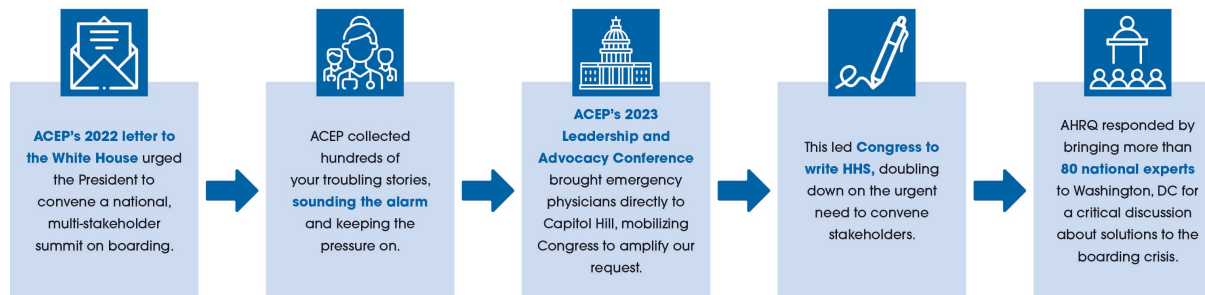
Triggers Staff Burnout: Managing inpatient care alongside fresh emergencies fuels severe burnout.

Poor Patient Experience: Long, frustrating wait times and a lack of privacy increase physical and verbal assaults on staff.

Increased costs: Longer inpatient lengths of stay

ACEP Advocacy Makes it Happen

Boarding in the emergency department is a national public health crisis that puts lives at risk.
On October 8, 2024, the Agency for Healthcare Research and Quality (AHRQ) held a national summit on boarding
— ACEP advocacy made it possible.



TOOLKIT FOR ENACTING MEANINGFUL LEGISLATIVE AND REGULATORY SOLUTIONS FOR ED BOARDING AND HOSPITAL CROWDING



HOW 2026 OPPS FINAL RULE IS CHANGING EMERGENCY CARE: A GUIDE TO THE 2026 OPPS ECAT MEASURE

THE PROBLEM: AN ED "PUBLIC HEALTH CRISIS"

ED Delays Linked to "Growing Public Health Crisis"

CMS justification cites patient harm and poor outcomes from extended ED stays and boarding.



"You cannot fix what you refuse to measure."

The American College of Emergency Physicians supports the new rule to drive accountability.



THE SOLUTION: UNDERSTANDING THE NEW ECAT eCQM

A New Composite Measure of ED Throughput

It uses EHR-extracted data to capture multiple dimensions of ED throughput and access.



FAILURE TRIGGERS



THE STAKES: TIMELINE & FINANCIAL IMPACT



While Reporting Begins in 2027, Prep Must Start Now

Performance during CY 2028 will directly impact hospital payments in CY 2030. Reporting in CY 2027 is optional.



2.0% Payment Reduction Penalty

Hospitals that fail to meet OQR reporting requirements will see this reduction in their annual payment update, including the new ECAT measure.



Hospital Star Ratings Are Also at Risk

CMS is now also penalizing hospitals more for poor performance in the Safety of Care measure group.

The Three Pillars of the ABC-ED Act

1. Bed-Tracking Technology

- Modernize infrastructure
- Expand real-time tracking
- Prevent patient placement delays

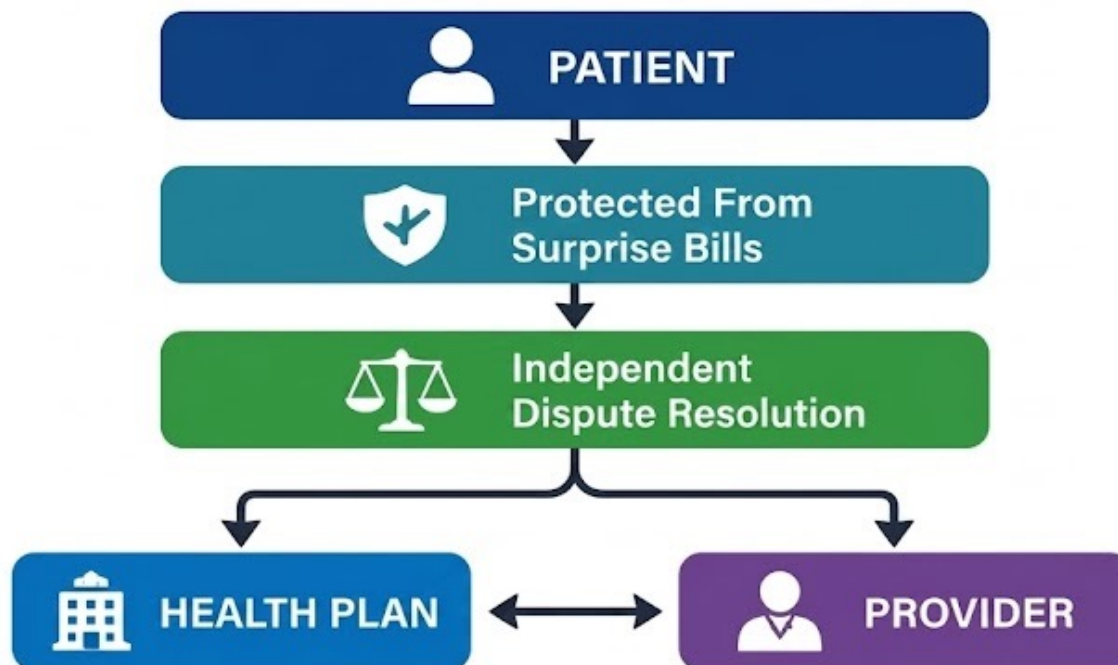
2. Pilot Care Models

- CMS Innovation pilots
- Optimize care transitions
- Focus on older adults & psych

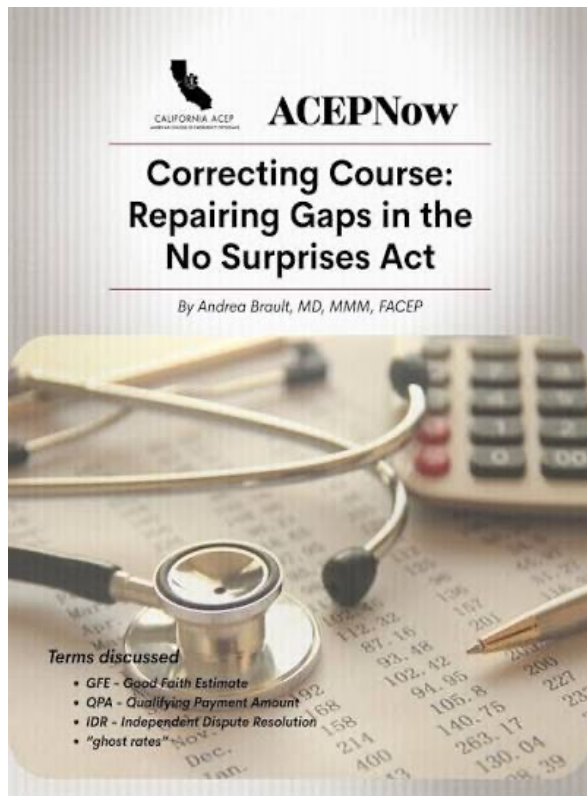
3. GAO Accountability

- Study tracking best practices
 - Evaluate wait times
 - Assess boarding impact

No Surprises Act: Protecting Patients While Preserving Access



- Patients are removed from billing disputes
- Emergency services remain protected regardless of network status
- Fair reimbursement is critical to maintaining physician workforce and emergency department access
- Ongoing federal rulemaking continues to affect implementation



Federal Independent Dispute Resolution Operations Final Rule

Lowers Costs: Drastically cuts the government-mandated administrative fee for filing a dispute from \$115 to \$15 per party.

Centralizes Negotiations: Requires the 30-day "open negotiation" period to begin and be tracked exclusively through the Federal IDR Portal, standardizing notices and response times.

Expands Batching: Allows providers to batch up to 50 related claims into a single dispute to reduce administrative burdens.

Improves Transparency: Mandates that insurers use standardized [CARC and RARC codes](#) on claim denials and establish a new [Federal IDR Registry](#) so providers can quickly identify plan specifics.

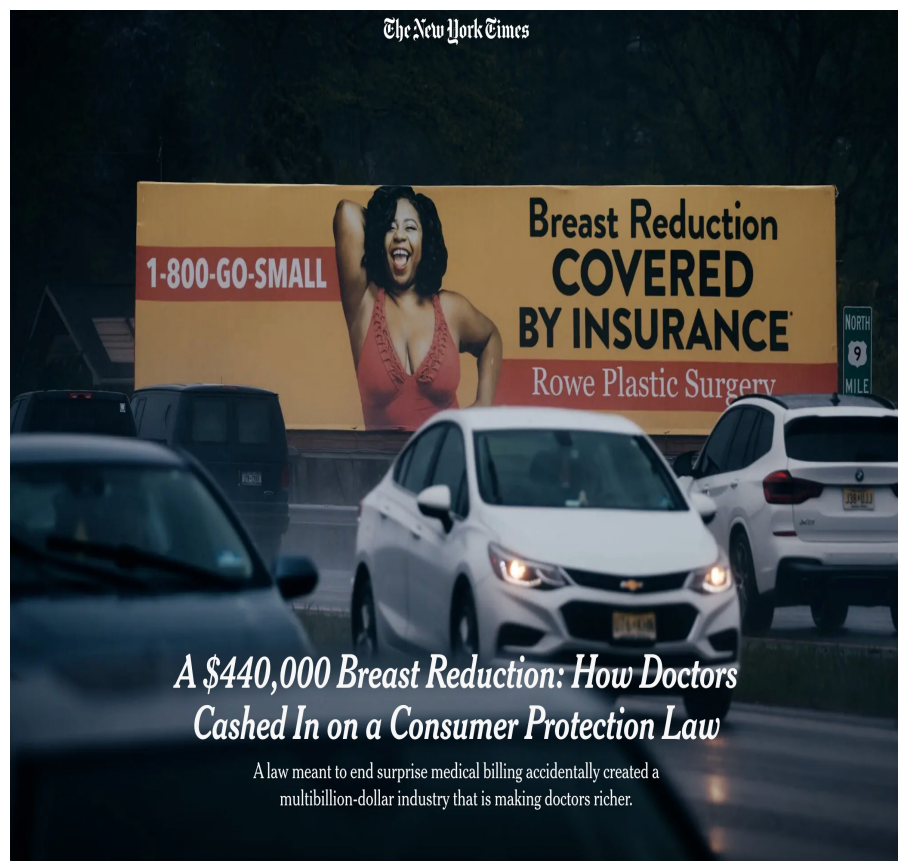
Streamlines Eligibility: Gives certified IDR entities up to five business days to determine if a claim is eligible for federal arbitration.

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- The **No Surprises Act Enforcement Act (NSAEA)** is a bipartisan, bicameral piece of federal legislation ([H.R. 4710](#) / [S. 2420](#)) introduced in July 2025 to **crack down on health insurance companies that delay or withhold mandatory payments to doctors**
- **Late-Payment Penalties:** It penalizes health insurance companies that fail to pay physicians within the 30-day statutory timeline following an Independent Dispute Resolution (IDR) determination.
- **Financial Triple Damages:** Insurers violating the 30-day IDR payment rule would face a penalty equal to three times the difference between any initial payment and the finalized out-of-network rate.
- **Consumer Protection Penalties:** It increases civil penalties to \$10,000 per violation for health plans that breach cost-sharing or consumer protection requirements regarding out-of-network emergency services or air ambulances.
- **Regulatory Parity:** The bill creates enforcement balance by ensuring insurance companies face the same rigid penalties and compliance deadlines that medical providers already face.



ACEP Responds to the New York Times: Congress Must Hold Insurers Accountable for Underpaying for Care

In a [letter to the editor](#), ACEP President L. Anthony Cirillo set the record straight on bad insurer payment policies and the flawed implementation of the No Surprises Act:

“Focusing on outliers dangerously misrepresents the real threat facing patients: a nationwide practice of insurer underpayment that is destabilizing our emergency medicine safety net.

Emergency medicine comprises over a third of all arbitration cases — more than any other specialty — because insurers consistently underpay for unplanned care. The No Surprises Act protects patients from surprise medical bills, but insurer practices threaten access to care.

Emergency physicians’ high win rate in arbitration isn’t evidence of gaming the system; it’s proof of systemic underpayment. Professional, neutral arbiters repeatedly determine that insurers’ payments are insufficient. Yet even after [losing more than 85 percent](#) of the time, insurers then fail to pay [nearly 60 percent of arbitration awards](#) within statutory time frames. These costly delays push our emergency medicine system to a breaking point, risking longer wait times and closures.

The real story is that an insurance industry is profiting by underpaying for care. Congress must pass the No Surprises Enforcement Act to impose meaningful penalties for nonpayment and protect the financial viability of emergency care for all Americans.”

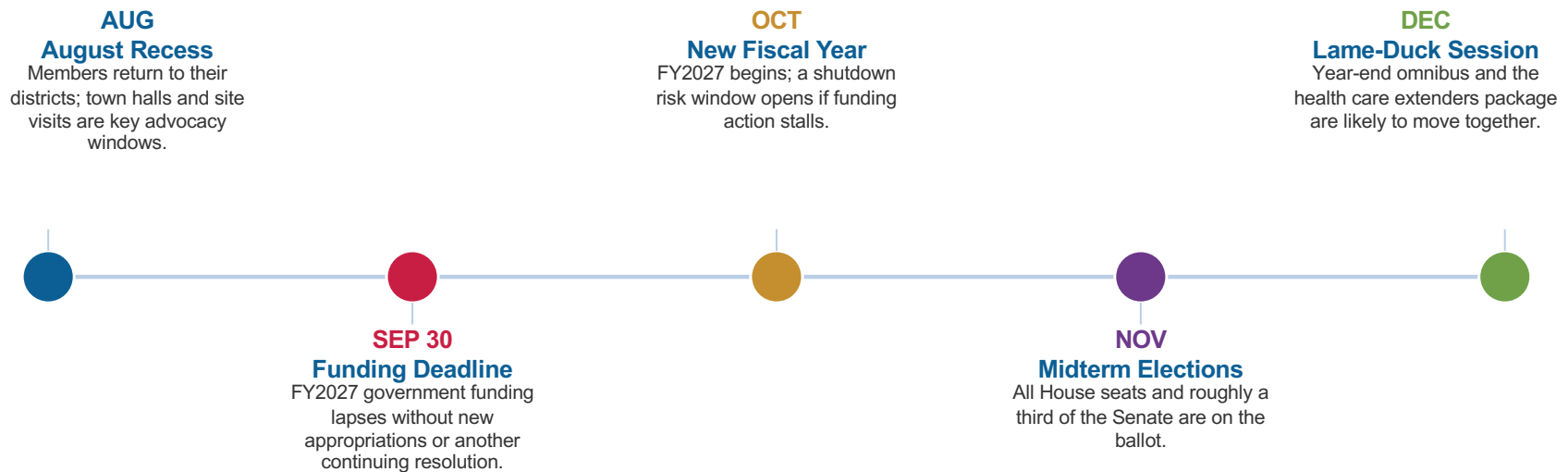
L. Anthony Cirillo
Saunderstown, R.I.

The writer is the President of the American College of Emergency Physicians.

[Leave a message](#)

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Congress CY2026 – What's Left?



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Physician Payment: The Landscape

Three payers, three distinct threats to fair payment for emergency care.

Medicare

Structural instability

- Conversion factor still lacks an inflationary update; cuts are averted only by short-term patches.
- Efficiency adjustment and indirect PE reallocation loom in CY2027 rulemaking.
- MACRA shortcomings: House working on updates/reforms

Medicaid

Underpayment & coverage risk

- Rates sit persistently below Medicare and commercial payment.
- OBBBA coverage losses threaten payer mix; more uncompensated care.
- Legislation: Rural Hospital Emergency Department Guarantee Act

Commercial

Insurer noncompliance

- No Surprises Act disputes marked by downcoding and underpayment.
- IDR backlog and missed statutory payment timelines persist.
- Consolidation and narrow networks pressure out-of-network rates.

CY2027 Medicare Physician Fee Schedule

Conversion Factor

-2.5% (OBBBA relief expires) + .25 non-APM update + .53 budget neutrality adjustment

-1.68%

Efficiency Adjustment Policy

No modifications, no new adjustments – continuing policy finalized in CY2026 rule.

NO CHANGE

Indirect PE RVU Reallocation

No major changes – requesting more information and data w/r/t hospital-based specialties. ACCESS Act should be ready to roll.

NO CHANGE (RFI)

Workplace Violence



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Save Healthcare Workers Act

- Establishes federal criminal penalties for violence against health care workers and hospital employees
- Guardrails for patients experiencing psychiatric crises, lacking capacity, etc.
- Based on existing protections for airline & airport workers
- Bipartisan, bicameral



Updating MACRA: The Patients First Act of 2026

1

Medicare PFS inflationary update

Provides an annual conversion factor update tied to inflation at MEI minus 1%.

2

Work GPCI increase

Boosts the physician work Geographic Practice Cost Index in high-inflationary years.

3

Replaces MIPS with POINTS

Retires the Merit-based Incentive Payment System in favor of the Patient Outcome Improvement National Tabulation System (POINTS).

4

Reestablishes Medicare AUC

Brings back the Medicare Appropriate Use Criteria program for advanced imaging.

5

Modernizes budget neutrality

Updates Medicare's budget neutrality requirements to reduce arbitrary payment cuts.

Challenges



EM casts a wide net – MANY different priorities

Three T's: 1) triage, 2) triage, 3) triage



Historically unproductive Congress

Fewer incentives for bipartisanship
More opportunities at regulatory level?



Dwindling congressional calendar

Off to the races!



Questions?



Answering Questions Through EMDI

Sandy Schneider, MD, FACEP | ACEP Chief Medical Officer
Dhruv Sharma, MS | ACEP Lead Data Scientist



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Our Mission



The American College of Emergency Physicians (ACEP) mission is to **promote the highest quality of emergency care** and to be the leading advocate for emergency physicians, their patients, and the public

Enable emergency physicians to lead the effort to design quality initiatives that improve outcomes

Think about your need/product

It's a common problem



Think about your need/product

ACEP traditional products

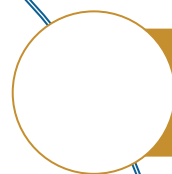
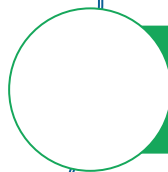


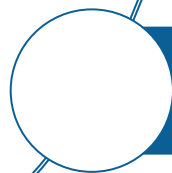
Exhibit Hall, Expert theaters, InnovateED –
Scientific Assembly, Accelerate



Sponsorships



Webinars



Podcasts

Think about your need/product

ACEP Anytime



Primary
learning
platform



Like Netflix:
Subscriptions +
free content

24/7

Used
24/7



Best content:
Short
audio/video



Think about your need/product

Level 1: Is This Patient Experiencing Acute Respiratory Failure? ▾

Non-Rebreather Mask (NRB) ▾

High-Flow Nasal Cannula (HFNC) and Non-Invasive Positive Pressure Ventilation (NIPPV) ▲

What is HFNC: High-Flow Nasal Cannula (HFNC) delivers heated, humidified oxygen at flow rates up to 70 L/min with adjustable FiO₂ (up to 100%), providing both oxygenation and low-level positive airway pressure for patients with respiratory distress or hypoxic respiratory failure.

LEVEL 2: Immediate Actions ▲

When should I choose High-Flow Nasal Cannula (HFNC)? ▾

Preferable when ▾

High Yield Uses in specific diseases (if available) ▾

Contraindications ▾

HFNC LEVEL 3: Modality Pages – “How To, How It Works, Pearls and Pitfalls” ▾

NIPPV (CPAP/BiPAP)



Find All ▾



Think about your need/product

Smart phrases

ARIA (Amyloid-Related Imaging Abnormalities)

Asthma Exacerbation

We evaluated you in the emergency department (ED) and believe that you have an exacerbation (worsening) of your asthma. Asthma is caused by inflammation and tightening of muscles in the airway. You were given breathing treatments and steroids, and your breathing improved. These medications will help with your current attack. A visit to the ED is a warning sign that your asthma may not be managed adequately. Asthma is a chronic condition that cannot be cured, but medications can help control your symptoms.

Steps to take at home:

- Use your albuterol (inhaler or nebulizer) as directed for your symptoms. If you have a spacer, we recommend using it to help deliver the medication to your lungs more effectively.
- Take the steroids (dexamethasone or prednisone) as directed to help reduce lung inflammation and decrease the risk of another attack in the next few days.
- Take your other home medications as directed.
- Follow up with your primary care doctor or pulmonologist (lung doctor) within one week to discuss your symptoms. They can talk with you about daily medications to help prevent asthma attacks. Ask them about writing an ["asthma action plan"](#) to prepare for future asthma exacerbations.

Please speak to your doctor or come back to the ED for new symptoms, such as difficulty breathing that doesn't improve with your medications, chest pain, voice changes, high fevers, confusion, or other new or worsening symptoms. Please review medication inserts for side effects and call the ED if you have any questions about the medications or care you received.

Asthma Exacerbation - Exacerbación del Asma (Spanish Translation)

Think about your need/product

How can we change practice?

- **Emergency Quality Network (E-QUAL):**

- ▶ Traditionally 3 phases
- ▶ Baseline data
- ▶ Education
- ▶ Repeat data for evaluation

- **EQUAL-Like**



Think about your need/product

How do we know about practice?

- Length of stay for patients with X condition
- Admission rate for X condition – variation by region and practitioner
- What meds are patients on who come to the ED
 - What do they get
 - What are they prescribed when they leave?

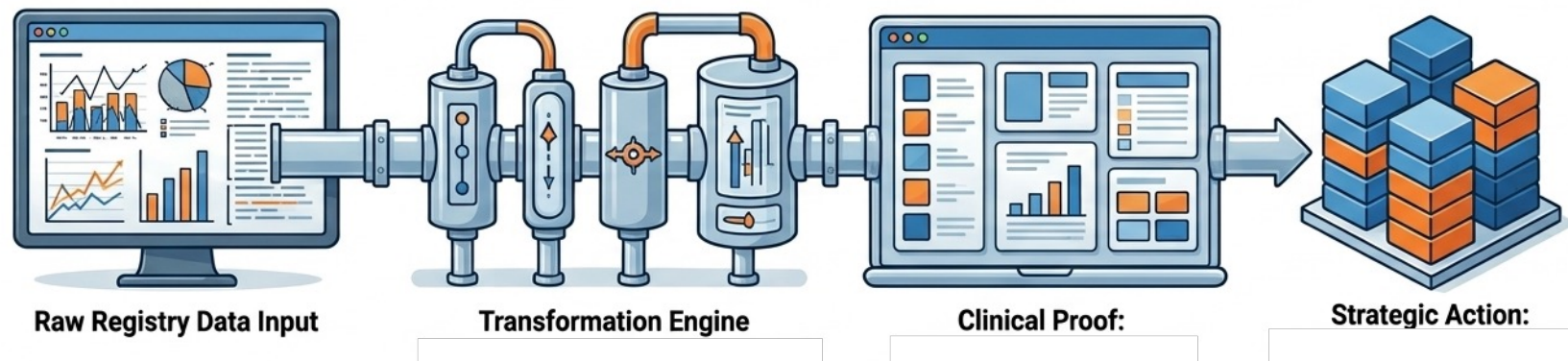
Think about your need/product

EMDI – ED medical records

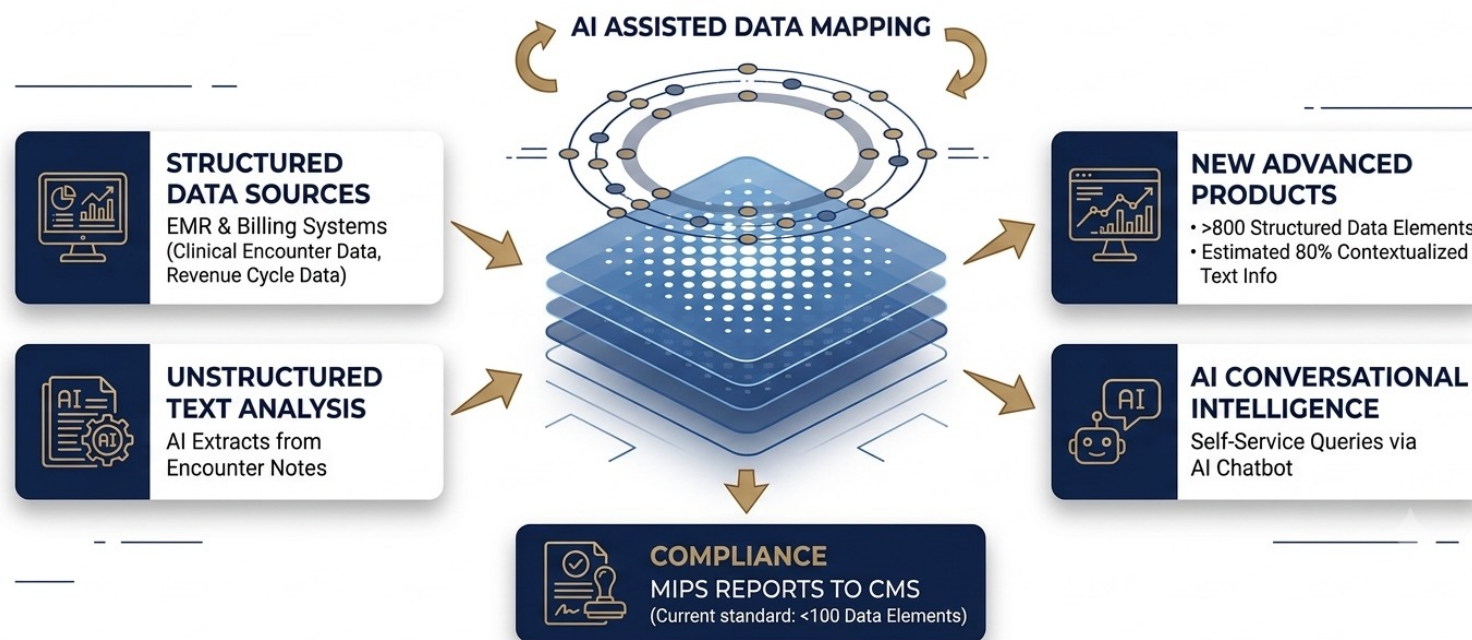
- Entire medical record from the ED current and prior years
- Many fields already mapped, more can be custom mapped
- Data from community and rural settings – fewer academic centers
- About **20 Million** visits added per year



Strategic Data Vision



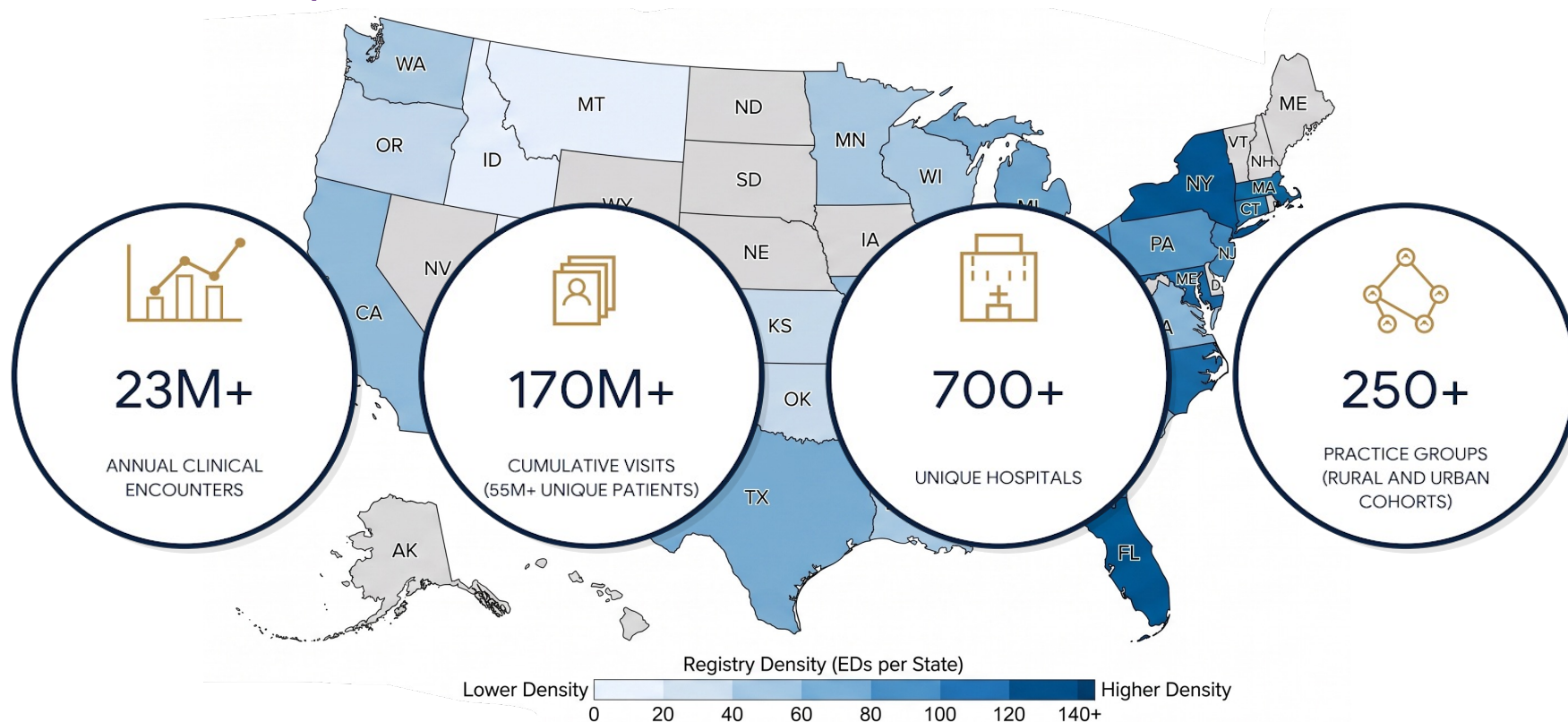
Emergency Medicine Data Institute (EMDI)



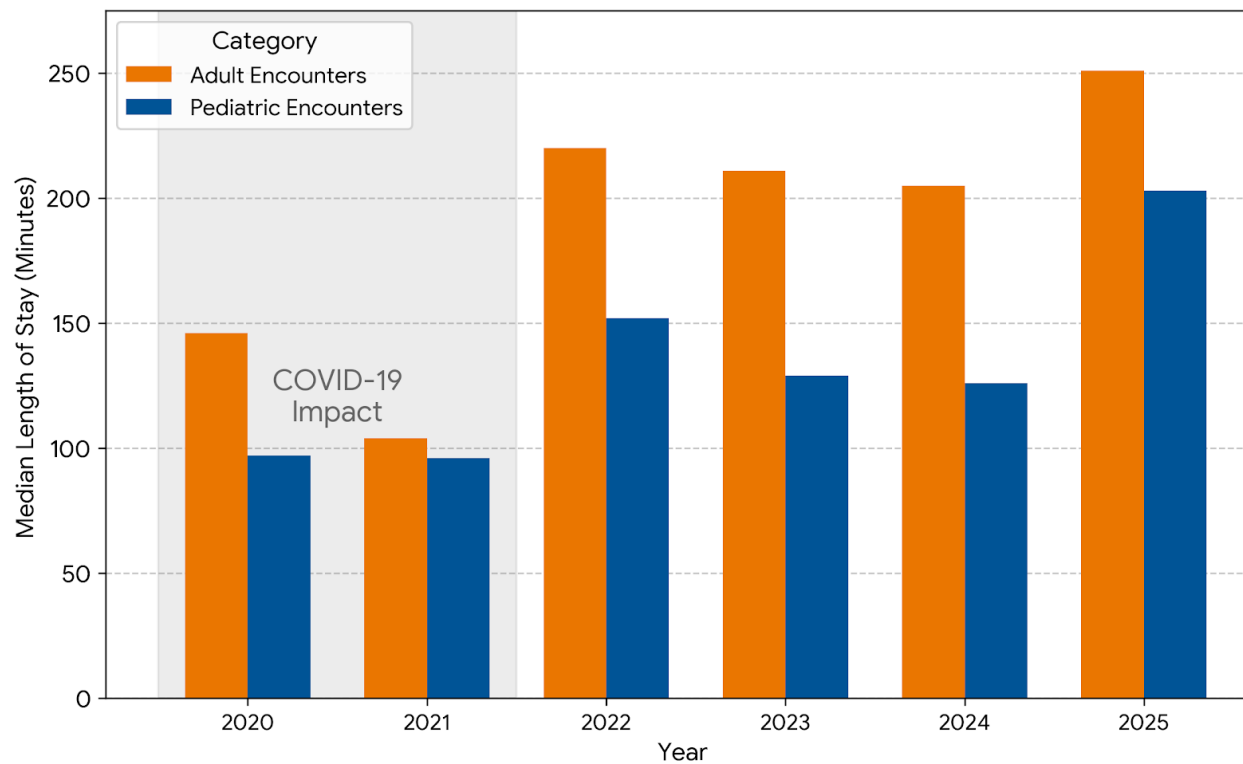
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CEDR's National Footprint



6 years of Increasing Length of Stay



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7:100,000 patient visits

Ruptured abdominal aortic aneurysm (rAAA) and aortic dissections are rare but fatal. Can we measure and improve outcomes?

EM Data Institute
≥3000 rAAA cases

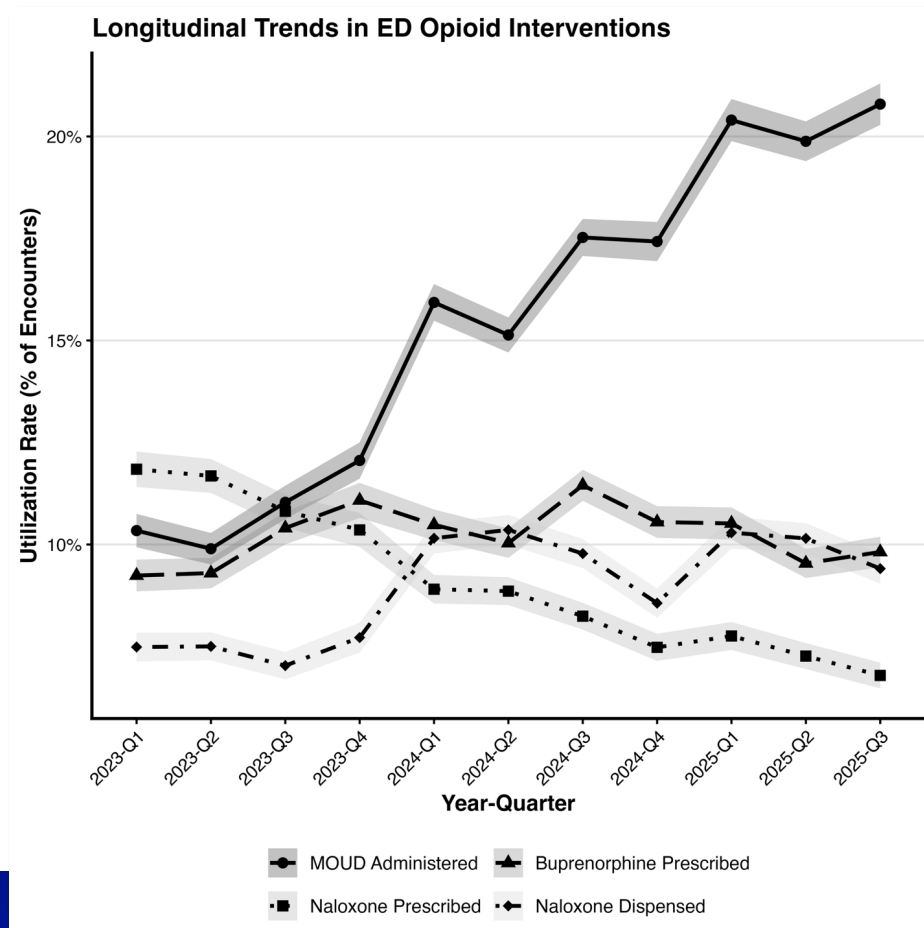
Developed a CMS measure:

Appropriate Utilization of Imaging in
rAAA patients.



Built a Point-of-Care tool:

Aortic Aneurysm Syndrome – The Ritter
Score.



MOUD in the ED

- Multi-year study using CEDR, E-QUAL
- CEDR for gap analysis
 - ▶ Built 3 new MOUD measures
- E-QUAL for quality improvement & educational dissemination

References



Pathways to Partnership

Solve high-impact problems

Align with ACEP members

Let us know what you need!

Data Analytics & Research

CEDR, E-QUAL, Accreditation

Point of Care Programs

E-QUAL, Education Dissemination

Registry Services

Build New Measures, MIPS services



ACEP Anytime



POC Tools



E-QUAL



EMDI

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The Substance Use Epidemic: ACEP Initiatives & Collaborations

Dr. Stephen H. Anderson MD, FACEP

July 22, 2026



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Stephen H. Anderson MD,FACEP

Retired ED Physician

MultiCare Auburn Med Center - 35 years

Past Chair of the Board-
the American College of Emergency
Physicians (ACEP)

Present Chair of the Board-
The Naloxone Project (TNP)

No Conflicts of Interest



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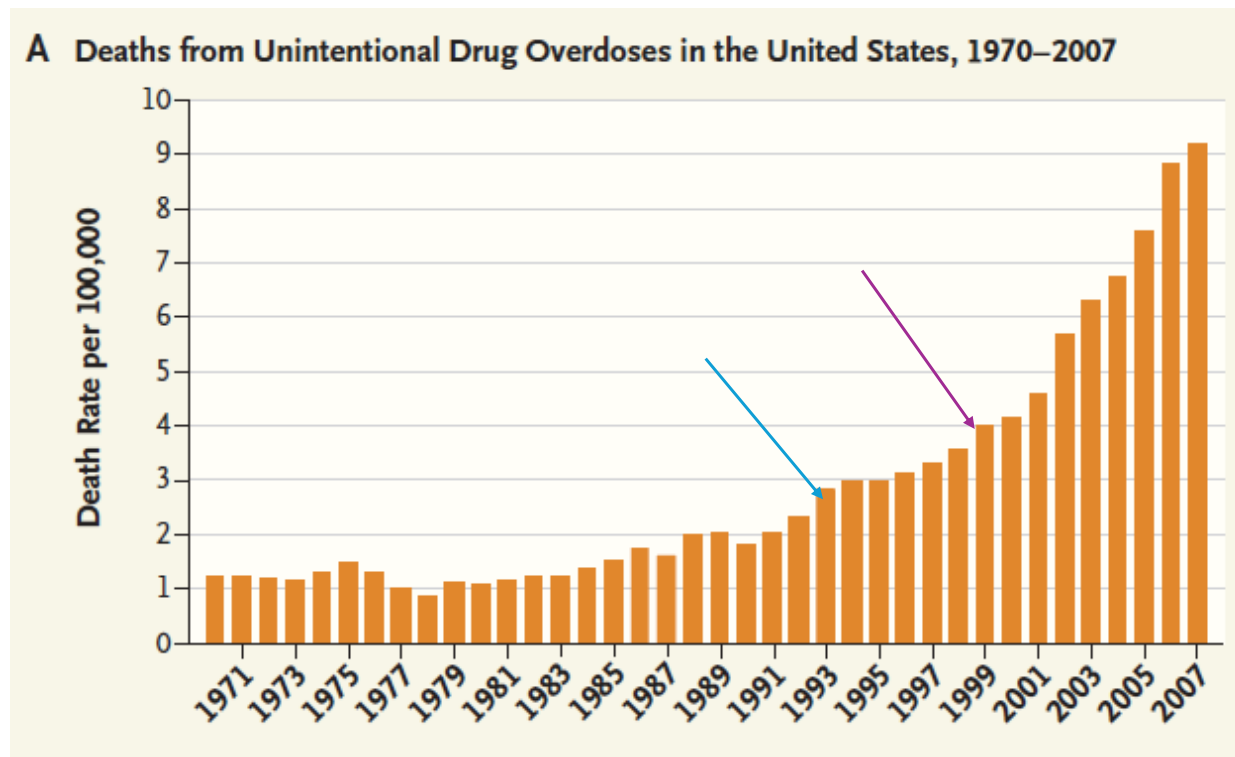


Historical Opium



- First used Medicinally in the Stone Age
- Sumerian, Assyrian, Egyptian, Indian, Minoan, Greek, Roman, Persian, & Arab Empires all report medicinal use.
- Fifteenth Century China first reported recreational use
- Opium Wars in 1839 & 1858
- 1804 first marketed Morphine
- 1874 first synthesized Heroin
- In 2010 the #1 written drug in America was Hydrocodone

Okie, NEJM, Nov 2010





Dying to be Pain Free

Examining the Problem & Solutions to
the Opioid Overdose
Epidemic in America

Dr. Steven Aks DO, FACEP

Dr. Stephen Anderson MD, FACEP



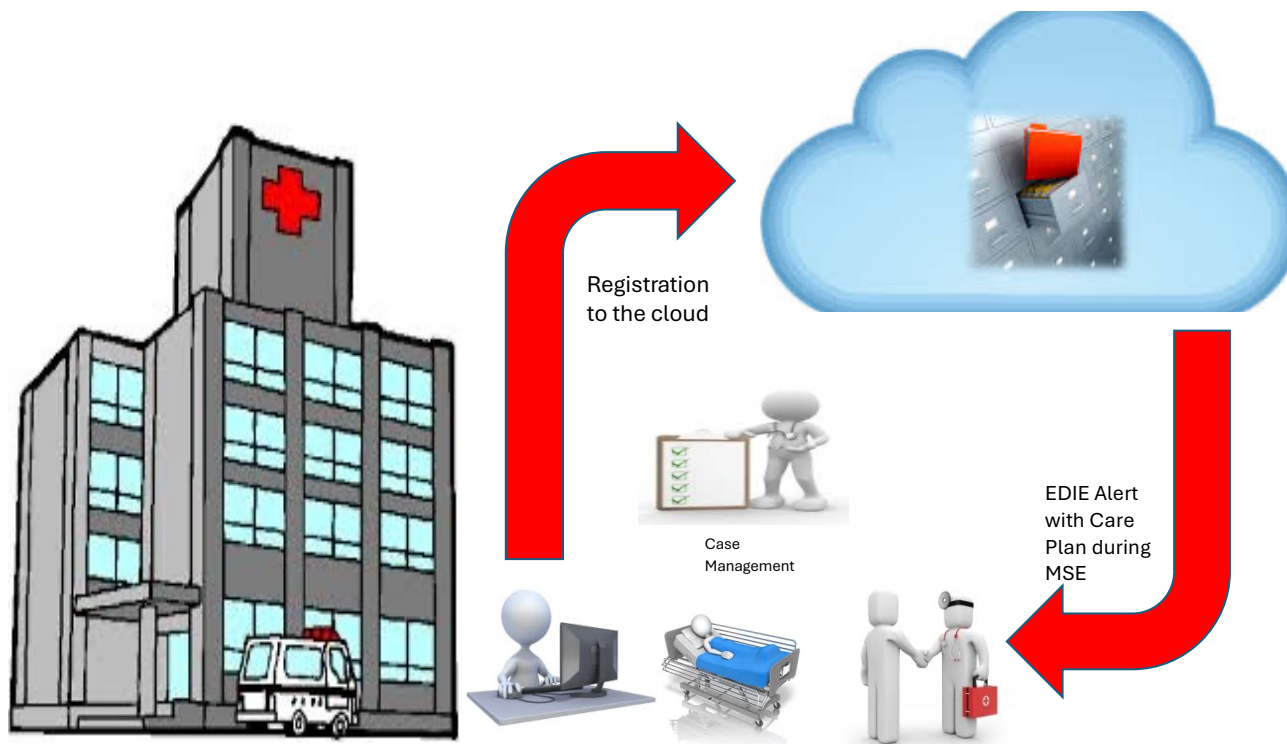
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In Response To A Legislative Directive

“The public (WA state) perceived the medical community as being unresponsive and not policing themselves.”

- ACEP lead a Task Force creating:
 - Guidelines for treating chronic pain.
 - Created a program for departmental treatment of pain-ALTO
 - Created a Section in the College- Pain Management & Addiction Medicine
 - National emphasis on PMP's (Prescription Monitoring Plans)
 - Instituted EDIE

Emergency Department Information Exchange



* Chris Klomp
Director of CMS

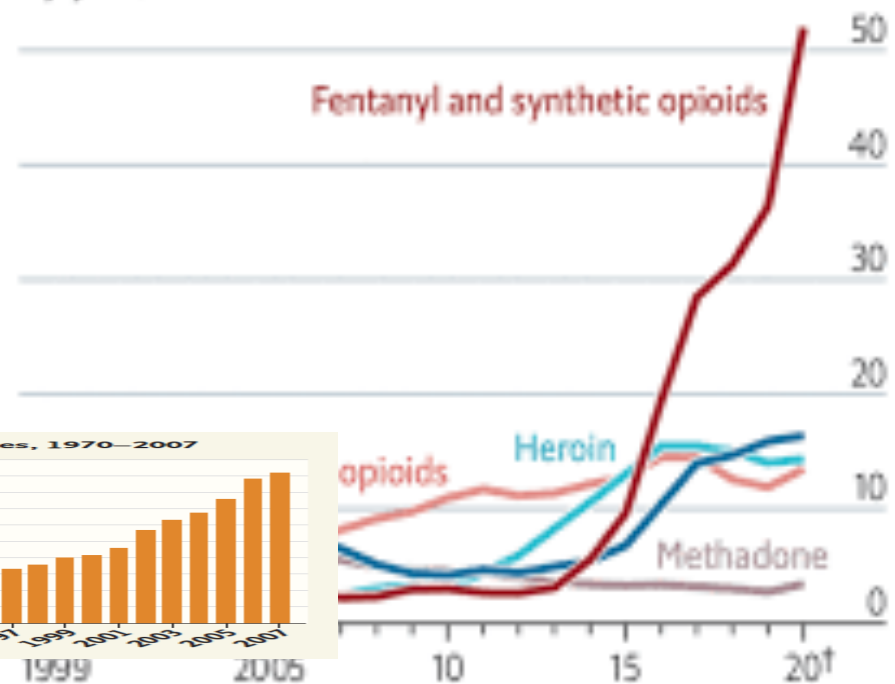
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Look
what happens when we
add in Fentanyl

The other epidemic

United States, drug overdose deaths*

By year, '000



Source: Centres for Disease Control and Prevention

The Economist

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One of the Aftermaths of CoVid & Isolation

- 1) In 2022 an estimated 111,000 Americans died of a drug overdose
- 2) It became the #1 killer of Americans ages 18-55
- 3) It became the #3 cause of death of teens ages 13-18

Time for a new plan

PACED Accreditation

American College of Emergency Physicians PAIN AND ADDICTION CARE IN THE EMERGENCY DEPARTMENT ACCREDITATION

*The Pain and Addiction Care in the Emergency Department Accreditation Program Board of Governors
declares to all that the management, personnel and procedures of*

Huntington Hospital

*has been found to meet or exceed the standards and requirements of the ACEP Pain and Addiction Care in the Emergency
Department Accreditation Program and therefore grants this*

Certificate of Accreditation



Effective July 7, 2022 - Expires July 7, 2025



William Schmitz, MD, FACEP

Mark S Rosenberg, DO, MBA, FACEP, President, ACEP

[Signature]

Alexis LaPorte, DO, FACEP, Chair, PACED Board

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PACED Addresses the Goal

The primary aim of the PACED program is to accelerate the transfer of knowledge about acute pain management and secure appropriate resources to care for patients.

The PACED program offers:

- Set criteria/standards for EDs in the management of pain and addiction.
- Established 3 Levels, with progressively higher standards.
- Policies, Guidelines, Toolkits, Podcasts, Point of Care Tools
- Education and Training



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The Traveling Road Show

- State Chapter Meetings and in Chicago at this year's ACEP2026
- Dr.s Aimee Moulin MD, FACEP, Evan Schwarz MD, FACEP, FASAM and Myself
- Establish MOUD programs
- Implement Naloxone Distribution Programs in the ED & Hospitals
- Building Peer Support education into residency training
- Combating STIGMA in the ED and Community

A large, light blue geometric graphic composed of several interlocking triangles and polygons, resembling a stylized star or a complex snowflake, positioned on the right side of the slide.

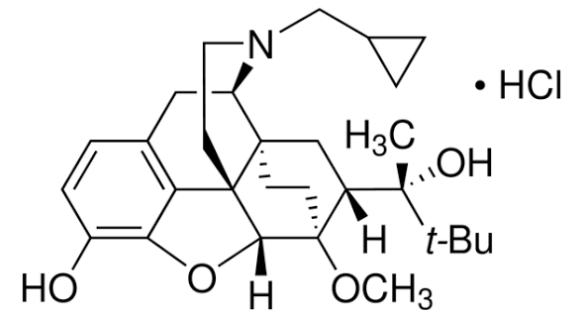
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Lengthy Discussion On Buprenorphine Induction Strategies

The concept of this was originally spearheaded by ACEP Leaders such as Gail D’Onofrio and others.

Providing High & Low dose protocols for induction of receptor blockade that eases withdrawal symptoms, improves compliance, and begins an alternative to further opioid dependence.

This can be the “first day of the rest of your life”.



Instituting Sustainable Naloxone Distribution Programs

Create sustainable systems that identify high risk individuals prior to discharge.

Directly hand the medication to individuals with the message:

“We care about your life. We want you alive. We now have programs to help you along the pathway to recovery, but we need you alive. Take this as our gift to you, with the message that you can always return here for help.”

In 2025, ACEP distributed 4,500 doses of Naloxone in Salt Lake City at ACEP 25 working with [The Naloxone Project](#). This year in Chicago we plan to distribute 6,500 doses



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Creating Peer Support Programs and Bridge Programs

- Someone who cares along the pathway to recovery increases compliance tremendously.
- Creating a pathway to further resources (MOUD, Healthcare professional, housing, etc.) is vital.
- Model after the California Bridge Program (lead by Cal ACEP members).
- “Anything done to us, without us, isn’t for us”.



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A hand is shown placing a wooden block with the letter 'O' into a row of four wooden blocks. The blocks are arranged to spell out the word 'STOP'. The first block has the letter 'S', the second has 'T', the third has 'O', and the fourth has 'P'. The blocks are light-colored wood with black letters. The background is a plain, light-colored surface.

S T O P

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This Has Focused On The #1 Killer... But SUD Is A Poly-Drug Epidemic

Methamphetamine

Medetomidine

Cocaine

Kratom

Xylazine

Benzodiazepines/Xanax

Marijuana derivatives

Just know,

Fentanyl is the cheapest drug to “cut other drugs with”
and is found in over 50% of all drugs sold on the street.

That, and Garage Chemists will always be one step
ahead of street antagonists.

Why do I rob banks?...

Because that's where the money is.

Willie Sutton

- Why is EM and ACEP devoted to solutions and collaborations to SUD?
- Because these are our patients. If you are going to overdose, have a complication, undergoing withdrawal, or seeking a pathway to recovery... You will likely land on one of our gurneys.
- We are committed to saving these lives and finding them a pathway to regain their lives.

Break
Next Session will start at 10:30am

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