

# Emergency Medicine Advocacy HANDBOOK

6th Edition

## *Editors-in-Chief*

### **Nathaniel Schlicher, MD, JD, MBA, FACEP**

EMRA Legislative Advisor, 2008–2010  
Associate Director, TeamHealth Litigation Support  
Regional Director of Quality Assurance, VMFH Emergency Departments  
Past President, Washington Chapter of ACEP  
Past President, Washington State Medical Association

### **Alison Haddock, MD, FACEP**

EMRA Legislative Advisor, 2010–2012  
Past Chair, ACEP Board of Directors  
BCM UME Thread Director, Preparing to Enter the Profession  
Assistant Professor, Baylor College of Medicine  
Dept. of Emergency Medicine & Dept. of Education, Innovation and Technology

## *Associate Editors*

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Baylor College of Medicine  
Chief Medical Editor, ACEP Now

### **RJ Sontag, MD**

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### **Maggie Moran, MD**

San Antonio Uniformed Services  
Health Education Consortium  
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# US Acute Care Solutions

US Acute Care Solutions is proud to offer an educational grant to support the *Emergency Medicine Advocacy Handbook*, 6th edition, furthering the tradition of promoting this and other EMRA activities.

Our commitment to EMRA is grounded in the belief that emergency medicine residency training is the gold standard for the practice of the specialty. We take pride in hiring emergency medicine residency-trained physicians, and we are pleased to support residents throughout their training.

The *Advocacy Handbook* is important because the practice of medicine is a business — yet there are fewer and fewer business models that put the physician at the center of the decision-making process. Therefore, participation in the legislative and policymaking arena is absolutely essential to delivering the highest level of patient care.

We are pleased to help provide a key resource to create an informed, proactive voice for emergency medicine.

With best wishes,

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# Foreword

Six months after we released the 5th edition of the Advocacy Handbook, the world changed for all of us with the COVID-19 pandemic. Overnight the world shut down for everyone else while we stepped up into the void, often under-resourced and exposed. Cheers rang out from the rooftops; cities came out to sing. *“Thank You Health Care Heroes! We are grateful for our frontline warriors! Brave soldiers of the pandemic, you are appreciated!”* Pizzas, donuts, shoes, discounts, and more were showered upon us.

## **How quickly the world forgot us.**

We lost friends to the virus and to the trauma of the frontline battle. As the dust settled, we lost scores more to burnout, moral injury, and fatigue. How did our policymakers recognize this service? The federal government, via CMS, slashed our pay. Insurers ramped up their attacks on emergency physicians, arguing we were overbilling for sepsis and other conditions. News channels on the far right attacked us as liars, charlatans, and vaccine pushers causing death, driving up vitriol and hatred towards us. Patients yelled about wearing masks in the emergency department lobby to keep the staff safe, argued the pandemic was a hoax, refused screening tests for inpatient bed placement, and generally increased the strain on an exhausted system. Hospitals became overcrowded and began a practice of record-setting boarding due to a need for surgical case revenue and an inability to discharge on the back end. We went from being heroes to being the face of everyone else’s pandemic fatigue while we struggled to provide care in the waiting room with shortages in staff and space.

## **We will never forget.**

Those who served on the front lines of this battlefield in thin paper gowns, reusing our masks, stripping to our birthday suits in our garages to keep our families safe, will not forget. **We cannot forget.** More important, organized emergency medicine will not forget. The Emergency Medicine Residents’ Association and the American College of Emergency Physicians have been and will remain steadfast in our support of our health care heroes. We will continue to advocate for support through legislation like the Dr. Lorna Breen Act to provide mental health resources to those providing the care who are struggling with the emotional toll of a pandemic that no one saw coming and fewer everyday want to acknowledge happened.

Together we will advocate for our specialty to be compensated for the care that we deliver by fighting back against big insurers and working with the government to stop automatic PAYGO cuts and reductions in the conversion factor. We will advocate for safe working environments and the rights of our colleagues to speak out when safety is an issue.

**We must not stop.**

As the next generation steps into leadership, you will bring the stories from the frontlines to the boardrooms so that the sacrifice of the pandemic years is not forgotten. Whether out of denial or desire, the world seems to be desperately trying to forget there was ever a pandemic. We cannot let that happen. The current challenges of emergency medicine in boarding, crowding, reimbursement, staffing, safety, mental health, and more have all been influenced and exacerbated by the pandemic. **We must bring these stories to the forefront to advocate for the change that will make emergency medicine the best place to practice.**

Whether you are new to advocacy or an experienced warrior in the trenches of the legislative and regulatory process, this book outlines the current issues facing emergency medicine. We hope it will provide a framework for your advocacy and be a resource as you embark on this journey. Remember, advocacy is what you do every day. It is built into the DNA of emergency medicine as we fight for those who, all too often, have been forgotten.

We helped save the world when a lethal new virus swept the globe. ***Nothing is impossible for emergency medicine.*** Join us in the fight for our future!

**– Nathaniel Schlicher, MD, JD, MBA, FACEP**

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# ANYONE, ANYTHING, ANYTIME: The EMTALA Story

*Moira Smith, MD, MPH; Cameron Grossaint, DO; Sachin Santhakumar, MD*

**Anyone, anything, anytime. This is the founding ethos of emergency medicine, and its legal basis can be found in the Emergency Medical Treatment and Labor Act (EMTALA).**

The law established definitions for a medical screening exam, stabilization, and criteria for transfer, which together influenced a large portion of emergency medical practice. However, as an unfunded mandate for care, it transfers the costs of insufficient access to care to emergency departments and the clinicians.

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*Through EMTALA, emergency medicine retains the ethos of “anyone, anything, anytime.” The ED is open every single hour of every day – for everyone. EMTALA creates the legal basis for this commitment.*

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## Why It Matters to EM and ME

Emergency departments are critical to the American health care system. As the most common entry point for the uninsured and acutely ill, EDs care for any patient who walks through the doors. According to the Centers for Disease Control & Prevention (CDC) and the National Center for Health Statistics (NCHS), between 2007-2018, U.S. EDs accounted for an average of 130 million visits annually.<sup>1,2</sup> To ensure this unequivocal right to emergency care, Congress passed the Emergency Medical Treatment and Labor Act in 1986, an unfunded mandate that guarantees a screening exam and stabilizing treatment, including hospitalization. This obligation applied to anyone who walked into a hospital-based ED, without regard for the ability to pay, making the ED a “safety net” for those who may have no other place to receive care.

The policy remains controversial, as its scope continues to expand yet remains unfunded, costing hospitals, physicians, and ultimately insured patients an exorbitant amount. According to a 2003 report from the Center for Health Policy Research, an emergency physician in the United States donates on average about \$140,000 each year in uncompensated EMTALA-mandated care — more than 10 times the all-specialty average.<sup>1</sup>

Taken in the aggregate, the amount of uncompensated care provided in emergency departments has exceeded \$50 billion annually.<sup>3</sup>

Even as individual emergency physicians provide more uncompensated care than others, they also face the real risk of fines that can apply to both the institution and the individual. These fines, in addition to the true nuclear option of removal of CMS reimbursement for an organization or individual, makes the stakes for meeting EMTALA requirements substantial. Both the Centers for Medicare & Medicaid Services (CMS) and the Office of Inspector General (OIG) have administrative enforcement powers with regard to EMTALA violations. There is a 2-year statute of limitations for civil enforcement of any violation. Penalties may include:<sup>4</sup>

- Hospital fines up to \$104,826 per violation (\$25,000 for a hospital with fewer than 100 beds)
- Physician fines of up to \$50,000 per violation (includes on-call physicians)
- Hospital opened to personal injury lawsuits in civil court under a “private cause of action” clause
- Termination of the hospital or physician’s Medicare provider agreement

EMTALA also requires that a patient be transferred to a higher level of care when the initial facility does not have the necessary services or specialists. Often this transfer is from a community site to a tertiary care center. However, this can also apply to transfers from one tertiary care center to another if the first facility lacks subspecialty care that is critical for the patient. Notably, EMTALA does not apply to the transfer of stable patients or care of a stabilized patient.

## How We Got to This Point

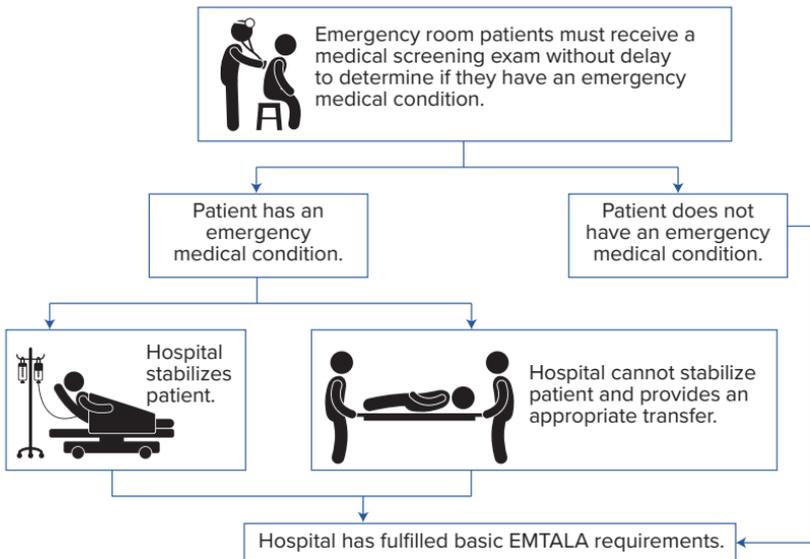
EMTALA was signed into law by President Ronald Reagan on April 7, 1986, as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. The act was passed in response to the widespread practice of “patient dumping” from mostly private community hospitals to county hospitals. At the time, 250,000 people a year were transferred based on their lack of availability to pay for care.<sup>5</sup> This leads to an unbalanced effect on patients from certain socio-economic backgrounds. Cook County, for example, noted 89% of patient transfers were minorities, 87% lacked employment, only 6% of these patients had given consent for transfer, and 24% of patients transferred had unstable conditions. Patients were twice as likely to die as a result of transfer.<sup>5</sup>

EMTALA established the following three main obligations:

1. For any person who comes to a hospital emergency department, *the hospital must provide for an appropriate medical screening examination... to determine whether or not an emergency medical condition exists.*
2. If an emergency medical condition exists, the hospital must *stabilize the medical condition* within its facilities or initiate an *appropriate transfer* to a facility capable of treating the patient.
3. Hospitals with more specialized capabilities are obligated to accept appropriate transfers of patients if they have the capacity to treat the patients.

EMTALA defines an emergency medical condition (EMC) as “a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual’s health (or the health of an unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs.”<sup>4</sup>

**Figure 1.1. Basic EMTALA Requirements**



### Medical Screening Examination (MSE)

All patients, regardless of insurance status, are entitled to an MSE if they are on a “hospital campus.” Through its inception, EMTALA has gradually defined this to be potentially anywhere on a hospital campus and within 250 yards of a hospital building. This would also include EMS vehicles owned or operated

by the hospital. Furthermore, a court appeals decision in 2001 *Arrington v. Wong* found this could include virtually any EMS service as well.

EMTALA requires an appropriate MSE for every person who seeks care at an emergency department, with a mandate to offer treatment “within the capability of the hospital, including ancillary services routinely available to the emergency department to determine if an emergency medical condition exists.” If a patient is found to not have any EMCs, EMTALA no longer applies. **Nursing triage alone does not meet the obligation to provide an MSE unless the nursing staff has been elevated to membership in the medical staff.**

MSE has been difficult to interpret, as neither the courts nor the Health Care Finance Administration have specifically detailed it. In general, an adequate MSE depends on the presenting symptoms and the normal standard of care required for such a case (vital sign monitoring, labwork, imaging, history and physical exam, consults). The biggest factor that must be satisfied is: Was the screening exam for a patient’s complaint similar to all patients, regardless of other factors such as insurance or ability to pay? In short, was the standard of care followed? The use of protocols in hospitals has been particularly helpful in MSEs, as they standardized patient care. Because protocols may vary according to patient encounter and complaint, any deviation must be documented and justified, as it can be considered evidence for an EMTALA violation.<sup>6</sup>

## **Stabilization**

All Medicare-participating hospitals must stabilize a patient if an EMC exists. Stabilization under the law is “treatment as necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of an individual from a facility or that [a person in active labor] has delivered the child and placenta.” If MSE reveals any EMC, stabilize the medical condition of the individual within the capabilities of the staff and facilities available at the hospital, prior to discharge or transfer without any clinical deterioration. Depending on the clinical picture, this step can take anywhere from hours to days to months. Stabilizing a patient often requires consultants from other specialties, which means the EMTALA requirements and penalties extend to them as well. Stabilization does not require a medical condition to be resolved. After stabilization, EMTALA no longer applies.

## Appropriate Transfers

If an EMC is found, a hospital must provide the medical treatment necessary to stabilize the patient or, if outside the capabilities of the hospital, transfer the patient to another facility capable of stabilizing the patient. The transfer must follow these criteria, often captured in standard transfer forms:

1. The transferring hospital provides medical treatment to minimize risk to the individual or unborn child's health.
2. The receiving hospital has available space, qualified personnel, and has agreed to accept and provide treatment.
3. The transferring hospital sends all available documents related to the EMC to the receiving hospital.
4. The transfer is effected through the use of qualified personnel and appropriate transportation equipment.
5. The transfer meets any other CMS requirement necessary in the interest of the individual being transferred.

Institutions must be aware of the nondiscrimination provisions, in which hospitals with specialized capabilities (NICU, burn center, trauma, etc.) must accept an appropriate transfer who requires the need for such care, if the hospital has the capacity to treat the individual.<sup>6</sup> If an individual or a representative of the patient refuses to consent to treatment and/or transfer after explaining the risks and benefits, then EMTALA obligation is considered to have been met. If a patient with an EMC is unstable for transfer and a provider refuses to authorize the transfer, the hospital cannot penalize that provider.

## Specialty Obligation

The federal statute mandates all U.S. hospitals that participate in the Medicare program “maintain a list of physicians who are on-call for duty after the initial examination to provide further evaluation and/or treatment necessary to stabilize an individual with an emergency medical condition.” If a hospital offers a specialty coverage to the public, then the service is expected to be available through on-call coverage of the emergency department.

## Current State of the Issue

EMTALA is still currently an unfunded mandate, meaning there is no designated funding to cover the “safety net” care that EMTALA ensures. The expansion of Medicaid under the Affordable Care Act has increased coverage, but a significant portion of the cost is absorbed by individual hospitals and health care systems as well as taxpayers.

EMTALA was based on an assumption that capacity would be available somewhere within the health care system if a particular hospital could not

provide the care a patient needed. By its nature as an anti-dumping law, it assumed there existed private hospitals with beds to accept these patients. In recent years, gradually increasing overcrowding at hospitals has been testing this assumption, leading hospitals to be at capacity more often and “closed” to transfers and admissions. This was only accelerated by the COVID-19 pandemic and subsequent staffing difficulties. Suddenly, not only did individual hospitals not have capacity, but sometimes entire cities, states, and even regions did not. As a result, there was flexibility added to EMTALA through blanket waivers. These allowed hospitals to modify the indicated parts of EMTALA without going through an approval process with CMS. Notably, adjustments were allowed to direct or relocate a patient to another location for their MSE and to allow for unstable transfers as long as it was in accordance with the local emergency plan and given that plan all efforts were taken to minimize risk from the unstable transfer.<sup>6</sup> While these changes are to be temporary, it appears the stresses on the capacity of our health care system are not. Thus the long-term impact on the application of EMTALA remains to be seen.

Through EMTALA, emergency medicine retains the ethos of anyone, anything, anytime. Emergency physicians see everything that encompasses the human experience, from the inception of life to death. Emergency medicine is an incredible field and the frontline of medicine. The ED is open every single hour of every day, for everyone – including the most vulnerable groups, from children suffering abuse to the elderly, uninsured, those without housing - anyone. Patients are seen under almost any circumstance as well, from mass casualties to pandemics. We provide a safety net for medicine by having the appropriate training and understanding of medicine to screen patients for emergent and critical conditions to elevate and deliver the care people need as soon as feasibly possible at any point in the day. It is EMTALA that creates the legal base that allows emergency medicine to hold to its ideals. This allows emergency medicine to play a critical role in the American health care system.

## **Moving Forward**

EMTALA will continue to be a core component of the promise of emergency medicine to care for anyone, anything, anytime. Emergency medicine’s continued support of this legislation keeps with the commitment to our patients first, regardless of demographics, socio-economics, or insurance status. However, it is important to continue to advocate for sources of funding for patients who are otherwise unfunded. Alleviating this financial burden will allow emergency departments to further the services they can provide to all patients. It is also important recognize that there are those that are advocating for the elimination of EMTALA or significant modifications that

could threaten the ability to continue to provide care to anyone, anything, anytime.

Additionally, EMTALA has far-reaching implications in many other aspects of health policy and emergency medicine practice. Recently this was most evident in discussions around insurance reimbursements. Given that emergency physicians have a mandate to see all patients, the typical dynamic of payers needing to negotiate with physicians in order for their customers to be able to access services no longer exists. Thus protections to reimbursement will rely on advocacy for protection from the government given the unique mandate from EMTALA.

## TAKEAWAYS

- EMTALA ensures that every citizen can receive a minimum level of care in the emergency department – but it is an unfunded mandate, putting EM at the intersection of public policy and economics.
- It is crucial to advocate for policies that support clinicians who offer EMTALA-related unfunded care.





# SERVING THE FORGOTTEN:

## The EM Safety Net

Jasmeen Kaur, DO

**The emergency department is the one place in the U.S. health care system where care is guaranteed, and for some patients, emergency care is the *only* medical treatment they receive.**

People using substances, those experiencing mental health crises, those with nowhere else to go come to the ED.

Individuals who visit the ED frequently can tax health care resources. Afflicted by limited or poorly coordinated primary care, chronic and psychiatric diseases, and a variety of socioeconomic factors, these high utilizers face an uphill battle in managing their health.

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*The emergency department is a critical safety net in American society – and frequent use of the ED is a critical benchmark for policymakers, payers, and the emergency medicine team.*

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### Why It Matters to EM and ME

Regardless of the name used for frequent users or high utilizers, the individuals who visit the ED frequently can account for a disproportionate share of ED visits and resource utilization.

Frequent use of the emergency department is a critical benchmark for policymakers, payers, and the emergency medicine team, as it indicates unmet social needs for patients with complex needs. These users may lack resources in the context of housing, social support, end-of-life planning, food security, or mental health care compared to non-frequent users. The emergency department is a critical safety net for these individuals, which positions us at a critical point to affect morbidity and mortality in these patients while advocating to improve their overall health condition.<sup>1</sup>

## How We Got to This Point

Questions about the appropriate use of EDs in the health care system and potential overuse have been debated for many years. Prior work shows that a majority of visits to the ED do not end in admission to the hospital.<sup>1</sup> Individuals come to the ED for many reasons, even seeking primary care because of convenience, accessibility, or problematic or non-existent insurance coverage. In the United States, the EMTALA law requires that EDs stabilize all patients, regardless of their ability to pay.

There are a number of potential reasons for concern regarding the overuse of EDs. Care provided in the ED can cost more compared to other sources of care. Overcrowding from a multitude of causes, including high utilizers, carries a number of adverse consequences, including longer wait times and worse health outcomes with higher mortality for all patients. When patients regularly use EDs for ongoing health needs, they do not receive the same continuity of care or preventative care they would from a primary care physician, which could affect the overall quality of care they receive and their health outcomes. One of the challenges in addressing potentially inappropriate utilization of EDs is that it is quite difficult for patients to determine what is inappropriate versus what's a true emergency.<sup>2</sup> Let us take a look at defining terms used to describe individuals who utilize the ED frequently.

### Defining High Utilizers

Patients with frequent ED visits are often portrayed as uninsured, unnecessarily clogging EDs by presenting with primary care complaints that do not need emergent service. But these widely held assumptions about the patient population who frequently visit EDs and their reasons for visiting have not been supported, for the most part, by research on the topic. Instead, the drivers of frequent utilization can be a lack of insurance, scheduling challenges while working, timely access to limited services such as mental health, more chronic medical conditions, and much more.

The definition of a high utilizer varies, but when defined as 4 or more ED visits per year, frequent users accounted for 4.5% to 8% of all ED patients. These patients contribute 21% to 28% of all ED visits.<sup>3</sup> Let us delve into the demographics and acuity these patients present with further. Among sex and racial groups, women and Black persons are disproportionately associated with frequent ED use. However, national data shows that in absolute numbers, the majority of frequent ED users are white (60%).<sup>2</sup> A bimodal distribution is observed, with increased risk in patients aged 25-44 years and those older than 65 years.

Insurance status has been central to discourse on ED crowding and ED “overuse.” Many studies on frequent ED use have considered the influence of insurance status and have found this patient population to be predominantly covered. The uninsured represent only 15% of frequent users and are no more likely to be frequent users than they are to be occasional ED users (<4 visits/year). Among all uninsured adults, only 2% use an ED 4 or more times per year. What has emerged from the data, however, is that a high proportion of Medicare and Medicaid patients frequently seek ED care.<sup>4,5</sup> Among those patients who can be characterized as “occasional” users, 36% are publicly insured versus the 60% of frequent users who carry Medicare or Medicaid.

Frequent ED users also tend to be sicker than occasional users. The probability of hospital admission is greater for frequent users versus occasional ED users. Frequent users have a preponderance of exacerbations of chronic illness such as renal failure, COPD, asthma, sickle cell disease. Patients younger than 65 years and receiving Medicare are associated with significantly higher rates of mental health diagnoses than any other group, whereas Medicare patients older than 65 years more commonly presented with cardiovascular, gastrointestinal, and urinary tract complaints.

Frequent users heavily rely on other parts of the health care system as well. They are more likely than occasional ED users to have made primary care visits in the previous year. These findings underscore the observation that most frequent users indeed do have primary care physicians. Compared with occasional ED users, these patients are more likely to be treated in a hospital clinic or have a change in source for their usual care; 19% reported unmet medical needs, another independent risk factor for ED visits. The finding that frequent ED visitors are about 6 times more likely to have been hospitalized in the preceding 3 months (odds ratio 6.1; 95% CI 4.1 to 8.9) reinforces their claims of unmet need.<sup>4</sup>

## Categorizing Frequent Users

To better understand this population, the Congressional Research Service outlined several categories of high utilizers based on their usage patterns which may lead to potential solutions.<sup>6</sup>

**Frequent non-emergent users:** This group includes individuals with private insurance and a primary care physician. These individuals may have barriers to accessing primary care resources leading them to seek care for non-emergent conditions. This group typically has fewer chronic illnesses.

**High-cost health system users:** These patients generally have 4-9 ED visits per year and have a high burden of chronic disease and are more likely to be severely disabled. They may have underlying mental illnesses or substance

abuse. This group is the most expensive for health care system, as they are more likely to require extensive testing.

**Very frequent ED users:** This group is a small portion (1.7%) of patients with more than 10 ED visits per year. This group is more likely to be male and suffer complex medico-social factors, including higher rates of disability, mental illnesses, substance abuse, and homelessness. They are less likely to require hospital admission and are less expensive for the health care system.

As evidence by these different categories and diverse drivers of emergency department utilization, this is a diverse group with an array of medical and social needs that must be addressed to affect the overall trajectory of ED utilization in the country.

## **Current State of the Issue**

In 2020, two significant events occurred to impact ED utilization: a global pandemic and the passage of the No Surprises Act as part of a COVID-19 relief package.<sup>7</sup> The effects of both are still playing out in every sector of the house of medicine – starting with emergency medicine.

The pandemic radically disrupted ED utilization: In the first year of the outbreak, weekly ED visits dropped by at least a third.<sup>8,9</sup> The sharpest declines were seen among patients with chronic conditions, but some studies also showed that super-utilizers continued to seek care in the ED for non-emergent conditions.<sup>10</sup> Emergency medicine absorbed the brunt of the COVID-19 crisis, yet the precipitous decline in patient volumes led to a cutback in staffing, even as burnout drove health care workers from the specialty.<sup>11</sup> Meanwhile, patients who delayed care for chronic conditions during the pandemic began experiencing acute problems, leading to a surge in emergency visits - stressing an already stressed system.<sup>12</sup>

Now three years removed from the start of the pandemic, emergency department volumes are recovering across the country with predictions showing that they are likely back already to pre-pandemic levels.<sup>13</sup> While federal data will lag behind for one to two years, most emergency physicians today are experiencing busier and more crowded care environments than before the pandemic as the challenges of staffing, increased health care demands due to delayed care, and more weighs on the emergency department care team. The question of whether the high utilizers will return at their prior levels remains to be seen in the data.

## Moving Forward

History has shown us that when resources are stretched thin and financial pressures begin to mount, the plight of the chronically ill social determinants challenged high utilizer of the emergency department can become a target for “quick” savings. As seen in the Great Recession when states like Washington sought to limit emergency department visits for those with high utilization, but emergency conditions, the need for emergency physicians to speak up is great.<sup>14</sup> It is likely that additional efforts to cost shift, eliminate coverage, and reduce perceived unnecessary emergency department care will be proffered in the future, often without addressing the underlying drivers of that utilization. Emergency physicians will need to continue to advocate for addressing the social determinants of health and holistically caring for the chronically ill patients rather than simply denial of care.

### TAKEAWAYS

- The emergency department is a critical safety net for patients with complex needs (such as: social admits, frequent flyers, “unnecessary” ED visitors, patients with opioid use disorder and mental health crises, unhoused patients) and can provide critical interventions to improve morbidity and mortality in these patients.
- The construct of “unnecessary emergency visits” fails to recognize the systemic issues leading patients to come to the ED and the critical role of the ED as a safety-net.
- Frequent utilizers can be scapegoated by policymakers as drivers of cost that can be easily eliminated with addressing the underlying barriers to care.





# THE PLUMBING IS BROKEN:

## Hospital-Based Congestion

Nathaniel Schlicher, MD, JD, MBA, FACEP

**The challenges of flow through and out of emergency departments have long been present, but the post-pandemic surge in volume, coinciding with a health care staffing crisis, pushed the situation to unprecedented and unsustainable levels.<sup>1,3</sup>** The now all-too-familiar practice of boarding inpatients in EDs, resulting in overcrowding for those seeking emergency care, has increasingly negative effects on the care to those most in need.

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*By targeting the problem of boarding and crowding, the solutions that allow each facility to address their unique, specific causes can be the focus of future policy, rather than a one-size-fits-all approach.*

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### Why It Matters to EM and ME

Crowding is defined by a 2014 Congressional Research Service report as “a situation in which the need for services exceeds an ED’s capacity to provide these services.” Boarding, meanwhile, is defined by ACEP as “the practice of holding patients in the ED after they have been admitted to the hospital because no inpatient beds are available.”<sup>4</sup> Both crowding and boarding negatively impact patient care – and that, in turn, compounds the stress experienced by the entire care team. A stark example can be found in the 2021 case of Ray DeMonia, who sought help for a cardiac emergency. His overwhelmed local hospital contacted 43 surrounding facilities asking for an ICU bed – to no avail. He was eventually accepted by a hospital more than 200 miles away, but it was too late and DeMonia died.<sup>5</sup> While a boarding-related death due to inpatient capacity is dramatic, all patients are negatively affected by inpatient boarding in the ED. Multiple studies documenting negative impacts on mortality, bouncebacks, length of stay, and patient satisfaction have resulted in increased calls for health science research on the true impact of this crisis.<sup>6</sup>

The impact of boarding is also profound on the care team. With increased delays, the stress in emergency departments continues to climb. Burnout among emergency medicine physicians remains high, with more than 60% of physicians

suffering from burnout in multiple studies.<sup>7</sup> Additionally, there has been a real financial cost to those that chose to deliver the care in multiple studies. One study reviewed a hospital's boarding problem and identified that it cost a single department nearly \$2 million in lost revenue per year.<sup>8</sup> That number skyrockets when the full impact of those lost visits, presumably a portion of which would have been admissions and high revenue procedures, is taken into account. This reduced revenue then reduces the ability to provide staffing of the entire care team, resulting in further delays and a downward spiral of increasing delays, worsened outcomes, and more pressure on the care team.

**Figure 3.1. Financial Impact of ED Boarding**



This image was published in *Annals of Emergency Medicine*, Vol 80, S. Straube, C. Peabody, N. Stark, C. Colwell, M. Singh, *The Waiting Game: Emergency Department Boarding and Its Financial Costs for Patients, Hospitals, and Clinicians*, S168, Copyright ACEP (2022). Reprinted with permission.

## How We Got to This Point

In the current health care system, emergency departments are responsible for more than just emergency care. Along with the original purpose of stabilizing seriously ill or injured patients, EDs fill the gaps in the overall health care system and often more broadly in the social services. EDs offer safety net care (for underserved populations), after-hours care, and management of acute exacerbation of chronic health issues. Addressing the social determinants of health has also become an increasing part of emergency care including housing and food resources. A significant gap in the supply and demand of primary and behavioral health care providers has added to the workload of emergency departments around the country as patients resort to an emergency visit when they can't get appointments for routine care.

Despite speculations that implementation of the Affordable Care Act would decrease ED visits, ED utilization instead trended upward over time. Since the

ACA's enactment, the type of payer visiting the ED initially changed, but the number of visits continued to rise in both Medicaid expansion and non-expansion states.<sup>9</sup> That trend was jarringly disrupted in 2020, as COVID-19 emerged, and the world locked down. ED visits dropped from 143.4 million in 2019 to 123.3 million in 2020.<sup>10</sup> Volume continued to drop in early 2021,<sup>11</sup> and a subsequent staffing crisis – driven by financially motivated layoffs and burnout-fueled attrition – began to gather steam, with the worst shortages felt among the nursing staff. By March 2022, the American Hospital Association approached Congress with concerns of collusion and anticompetitive behavior by staffing companies, which it said was one of the factors driving crisis-level shortages of health care workers.<sup>12</sup> In the end, there was a perfect storm of lower staffing and return of higher volumes that put the pressure on the staff providing care.

**While there are multiple factors that have driven the challenges of inpatient boarding, the universal challenge has been that the EDs are the safety valve for the entire hospital.** When inpatient beds are overfilled, the ED holds the patients through the practice of boarding. Profitable surgeries are not stopped to slow the influx of elective patient procedures. In contrast, the ED is always open, and the volumes on average are consistent and the admission rate a relatively predictable rate.<sup>13</sup>

With governmental entities at the regional and state level going to no-divert policies for EMS,<sup>14</sup> the ability to turn off the inflow to the ED is eliminated. The addition of nurse staffing ratios in states like California can result in closed beds upstairs with patients boarding in the emergency department. Add to that shortages of mental health resources<sup>15</sup> and outpatient care facilities, and the burden can become overwhelming on the one department that cannot say no. All roads lead to the ED care for inpatients and those struggling to access outpatient resources, thus diverting care and resources away from the new undifferentiated emergency patient in need of timely care that they increasingly cannot receive.

## **Current State of the Issue**

Boarding has become so pervasive that emergency medicine conferences routinely host educational sessions on how to successfully conduct hallway medicine. Yet in 2021, CMS abandoned a quality measure tracking patients' stay in the ED.<sup>16</sup> Currently there is no financial incentive or quality metric that forces hospitals and health systems to address the inpatient boarding and overcrowding crisis. Without appropriate incentives, there is little impetus to drive change and investment in emergency department care that many health system executives see as costly and lower revenue generating than elective surgical care.

As a result of this lack of current incentive to address this ever increasing crisis, ACEP, joined by nearly 40 additional organizations from throughout the house of medicine, appealed to President Joe Biden in November 2022, asking the

administration to recognize boarding as a major threat to public health and to prioritize solutions.<sup>17</sup> More than 100 emergency physicians shared personal stories of the negative impact of boarding, reflecting profound moral injury and frustration over an inability to offer optimal care.<sup>18</sup>

*“It’s embarrassing to have such limited resources to offer patients who arrive in distress. I am aware of at least two cases where someone has died due to delays in being seen. Multiple providers have left our department due to the stress of an untenable work environment. We have been asked to do more with less to the point that it feels like we are expected to do everything with nothing.”*

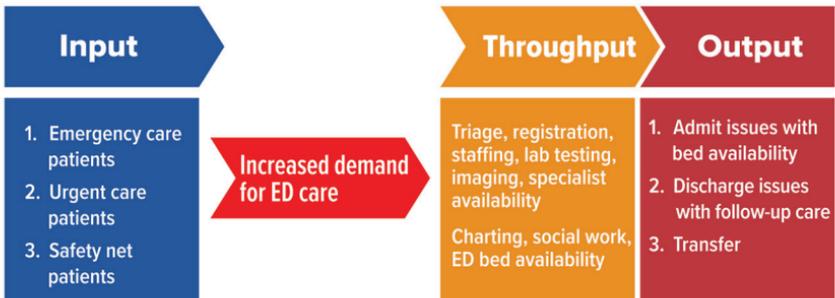
As organized medicine seeks relief through policy measures, researchers are also calling on hospital system administrators to view the worsening crowding and boarding not as an ED efficiency problem, but as a hospital throughput issue.<sup>19,20</sup> Unless efforts to address the problem are undertaken, there is little doubt that the crisis will continue to grow unabated.

## Moving Forward

Solutions to the boarding and crowding issue can be grouped into two categories: internal and external to the emergency department. Much of the work in boarding and crowding to date have focused on the efforts to improve throughput in the emergency department through work on turn around times, rapid triage and treatment, and alternative care locations. The pandemic and current staffing challenges have demonstrated in excruciating detail that the cause of boarding and crowding is mainly external to the department. While we can work to optimize care in the ED, any substantial improvement will come through addressing the external problems of surgical loading, inpatient bed management, long stay patients, and other external drivers of overcrowding.

The ACEP Emergency Medicine Practice Committee’s guidelines focus on modifying input, throughput, and output of patients from the ED. This model can be useful in identifying factors that contribute to or relieve ED crowding (see figure).

**Figure 3.2. Emergency Department Flow**



While it's important to know the pain points of crowding, the solution ultimately hinges on eliminating ED boarding – which requires systemic change. Teams are studying many potential ways to approach the issue:

**ED observation units:**<sup>15</sup> In a 2021 advisory, the Joint Commission recommended establishing observation units for psychiatric patients boarding in the ED, among other measures aimed at addressing mental health needs in a more timely manner.

**Multidisciplinary rounding:**<sup>21</sup> Studies have demonstrated reductions in length of stay on the inpatient medicine floor of a 30-bed regional transfer center after a multidisciplinary care team began daily rounds. These check-ins included focused discussion about expected discharge date, therapy and medication needs, discharge destination, and outpatient medical device requirements. “By implementing a daily MDR along with an improved understanding of how capacity and demand influence patient outcomes, reducing ED overcrowding and boarding became a mainstay for this project team.”

**ED ICUs:**<sup>22</sup> Critically ill patients, by necessity, require the most resources – so boarding them in the ED is especially disruptive. An economic analysis showed that implementing an ED-based ICU improved quality without increasing cost.

**Hallway medicine:**<sup>23</sup> As subpar as it is, a simulation experiment showed boarding patients in hallways rather than in ED exam rooms could help improve throughput and overall hospital length of stay. Patients have also reported higher satisfaction with inpatient versus ED boarding. Regardless of the location, moving the patients out of the emergency department can increase flow and re-deploy ED staff to care for emergent patients.

**Patient flow teams and quality measures:**<sup>24</sup> The Agency for Healthcare Research and Quality in 2018 released stepwise instructions to address crowding and boarding by improving patient flow. The report recommends assigning a team to implement and track quality measures, adjusting operations accordingly.

**Surgical level-loading:**<sup>25</sup> While ED admission volume is predictable and relatively steady, the surgical admission volume varies greatly over a week, concentrated towards the early weekdays resulting in peak boarding throughout the midweek. By smoothing surgical admission stays and leveling it over seven days of the week, excess hospital capacity can be utilized and the congestion in the ED reduced.

**Difficult to discharge patients:** The challenge of an aging population with increasing chronic disabilities combined with behavioral health challenges can lead to prolonged stays in the inpatient hospitalization awaiting an accepting post-discharge facility.<sup>26</sup> These patients are medically stable, but are unable to move out of the inpatient environment. This delay in discharge not only results in increased length of stay and overcrowding, but impacts hospital financial performance as no additional revenue is received, further increasing

the potential for reduced staffing and resources. Addressing the barriers to discharge can help reduce overall congestion.

Each hospital and health system will have its own unique combination of causes of inpatient boarding that can include unbalanced schedules, difficult outflow, lack of staff, and inadequate physical plant space. Regardless of the cause, there are currently no financial or quality measures with significant pressure that can result in a systematic approach to addressing the problem. As such, arriving at a financial cost to continued poor care such as the work done with hospital readmissions or a quality incentive that could be attached to various standings like door to balloon time for heart center designation, will likely be required to make significant progress on the issue. To this end, ACEP created a task force on boarding and crowding in 2023 to begin to outline long-term systemic solutions to the problem that could be considered by the government and payers to help motivate the change we need to address the problem. By targeting the problem of boarding and crowding, the solutions that are unique to each facility to address their causes can be the focus rather than a one-size-fits-all approach to mandating solutions.

## TAKEAWAYS

- Crowding is caused primarily by boarding and hospital inpatient bed availability, rather than low-acuity emergency visits.
- Boarding is a function of inefficient use of a fixed asset (hospital beds) to cap volumes. Maintaining high capacity helps a hospital's bottom line, but allows little wiggle room for surges or pandemics.
- Lack of capacity in the system for mental health patients to get intensive outpatient or necessary inpatient care (especially special populations - children, pregnant patients, patients with medical comorbidities).
- Solutions to the problem must include appropriate financial and quality levers to motivate each organization to solve the unique causes of their lack of capacity.



# HEALTH BEYOND HEALTH CARE:

## Social Determinants of Health

*Sriram Venkatesan, FAWM; Mackensie A. Yore, MD, MS; Valerie A. Pierre, MD, FAAEM*

**Social circumstances play a consequential role in the health of patients with complex needs (lack of housing, substance use disorders, mental health disorders, etc.).** As part of the frontline medical team, emergency physicians are obligated to stand up and advocate on behalf of their patients to provide optimal patient-centered care.

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*Systems of emergency care are evolving to respond more holistically to patient needs and to raise awareness of the role of social and structural factors on both individual and public health.*

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### Why It Matters to EM and ME

The ED is the gateway to the health care system, accessible at all times to our country's most vulnerable patients, regardless of their socioeconomic background. Millions of Americans, impacted by social needs, rely on the ED for routine and urgent medical care. For this reason, it is often referred to as a "window into the community," through which emergency medicine providers regularly witness and care for people affected by disparities associated with adverse social determinants of health (SDoH).<sup>1</sup> The Centers for Disease Control and Prevention (CDC) defines SDoH as "conditions in the places where people live, learn, work, and play, that affect a wide range of health and quality-of-life-risks and outcomes."<sup>2</sup> According to data from the Healthcare Cost and Utilization Project, the high reliance on ED services was largely due to non-health care factors, including education, employment, and poverty concentration that had nearly as strong a relationship with ED utilization as health status.<sup>3</sup> Given the complex needs of many ED patients, physicians should strive to address the medical and social needs of each patient we encounter, to give equitable care across the board.

During the unprecedented COVID-19 pandemic, emergency medicine played an integral role in meeting the challenges of this crisis. As one of the few specialties with direct patient contact at the time, emergency physicians were uniquely positioned to correct public misconceptions and promote more appropriate

social distancing, mask wearing, and other health and hygiene practices. The shift in public perceptions based on current communications in the United States presented EM with a rare outlet to spearhead patient education efforts about the virus.<sup>4</sup> While their normal scope of duties is typically limited to engaging with patients to coordinate their immediate care, the COVID-19 pandemic provided the opportunity to have more broad-ranging conversation with the public about a multitude of health topics. The COVID-19 response also led to emergency physician leadership in various levels of government and the private sector, providing an opportunity to advocate for the broad determinants of health impacting our patient population. Since then, there has been greater demand for emergency physicians to take up larger roles in various areas of government and public health spheres, to draft and lead future emergency response plans and guidelines.<sup>5</sup>

## How We Got to This Point

One of the first notable discussions addressing SDoH can be traced all the way back to the early 18th century as a response to the Industrial Revolution. Rudolf Virchow, a German physician and statesman known for his work in pathology and forensics, famously wrote, “If medicine is to fulfill her great task, then she must enter the political and social life. Do we not always find the diseases of the populace traceable to defects in society?” in response to the typhoid epidemic in the 1840s.<sup>6</sup>

The concept of SDoH, however, was not introduced to U.S. policy until much later, when President Lyndon B. Johnson declared a war on poverty in his State of the Union address on Jan. 8, 1964. He subsequently signed the Economic Opportunity Act, which led to the eventual rise of several federal programs including Medicare, Medicaid, Supplemental Nutrition Assistance Program, Job Corps, and Head Start.<sup>7</sup> Social issues that predominantly affect impoverished communities, such as crime, hunger, housing, and transportation were recognized by most of the country; however, they were not adequately addressed until almost 20 years later, when hospitals began hiring social workers to connect patients with community support services. In 2010, the U.S. Congress passed the Patient Protection and Affordable Care Act, colloquially known as Obamacare. The law aimed to promote overall public health, recognizing the association between poverty, lack of health insurance, and health care disparities. Through Obamacare, a \$10 billion fund to expand national investments in prevention and public health was established.<sup>7</sup>

Since then, the health care community in the U.S. has steadily tried to incorporate SDoH-centered care into practice. Political disagreements over the future of publicly funded health care, however, kept health policy innovation mostly stagnant until the onset of the COVID-19 pandemic in 2020. The sharp increase in health care utilization combined with the universal lockdown and

social distancing created a “perfect storm” of challenges that rocked much of health care to its core. A study by the CDC that surveyed more than 16,000 families during the peak of the pandemic in 2020 highlighted this compounding effect that COVID-19 had on households, across the spectrum of social needs. The study revealed that 76.3% reported concerns about financial stability, 42.5% about employment, 69.4% about food availability, 31.0% about housing stability, and 35.9% about health care access.<sup>8</sup> Another study conducted by Feeding America, a U.S. based nonprofit with a nationwide network of more than 200 food banks, showed that 45 million adults (1 in 7) and 15 million children (1 in 5) experienced food insecurity in 2020.<sup>9</sup> SDoH was suddenly forced back into the limelight and became such a focus that CMS created a “roadmap” to help states address the root causes in order to “improve outcomes, lower costs, and support state value-based care strategies.” Then CMS administrator Seema Verma said, “The evidence is clear: social determinants of health, such as access to stable housing or gainful employment, may not be strictly medical, but they nevertheless have a profound impact on people’s wellbeing.”<sup>10</sup>

Today, SDoH remains a major focus in health equity conversations across the country. As of June 2022, there are 114 bills before the U.S. Congress that mentions SDoH in some form, and public and private sector corporations are increasingly looking into new ways to set measurable, practical goals to play their part in guaranteeing equal access to resources for all.<sup>11</sup>

**FIGURE 4.1. Social Determinants of Health**



## Current State of the Issue

Our field's efforts to address social conditions that affect health have grown in recent years and taken many forms. These efforts have included raising awareness about the influence of social and structural factors on health, examining the role of bias and discrimination in medicine in contributing to health inequities, including social workers and case managers in the ED care team, implementing ED-based screening and intervention programs for social needs, and advocating for health, social, and economic policies.

The Emergency Medicine Model of Clinical Practice, developed by the leading accreditation, curricular, and professional organizations in emergency medicine lists the ability to “recognize age, gender, ethnicity, barriers to communication, socioeconomic status, underlying disease, and other factors that may affect patient management” as a core task for emergency physicians.<sup>12</sup> In line with this objective, EM training and continuing education has begun to include a greater emphasis on the SDoH and building skills to ask patients about and consider their material needs when developing treatment and disposition plans. This has been done in a variety of ways, including development of EM-specific SDoH curriculum, SDoH-related journal clubs, and neighborhood walking tours to shelters, food banks and other locations that provide social resources.<sup>13-15</sup> Along with SDoH, there has been increasing awareness of the structural determinants of health, which are economic systems, institutions (eg, health care, education, carceral), and policies that underlie social conditions, affect individual agency, and place disproportionate burden on underprivileged groups.<sup>16</sup> Many physicians still have little exposure to historical issues like redlining, that impact the health of the communities they serve. General competencies to understand and address the structural determinants of health as a clinician have also recently been translated for an EM audience.<sup>17</sup> More resources to educate trainees and physicians on the history of discriminatory housing/lending policies, the stark health disparities rooted in gun violence, lead levels, access to primary care and life expectancy have also proven to be effective.

The field of EM has also started to acknowledge the ways in which it, and the institution of medicine more broadly, has contributed to health inequities. We now understand that there are racial and other demographic differences in the care delivered in the ED. For example, recent research has shown that Black, Latino, and Native American patients receive lower acuity triage scores than white patients for similar clinical conditions and that Black and Latino men on involuntary psychiatric holds are more likely than other patients on psychiatric holds to be placed in physical restraints.<sup>18,19</sup> There has been a call to action for doctors to do better, for example, by participating in anti-bias training, supporting underrepresented minorities in medicine to enter and remain in the field, learning about the history of race and racism and America and how racism

affects health, and reporting excessive force by police manifesting in injuries treated in the ED.<sup>20</sup>

EM has been increasingly recognized as an interdisciplinary and collaborative field that needs the expertise of social workers and case managers as much as it does physicians and nurses to deliver high-quality care. Social workers and case managers now routinely help with follow-up care, discharge planning, and additional resources for intimate partner violence and substance use disorders. While a recent study in New England showed that 93% of EDs now have access to a social worker at certain times, only 27% have access 24/7, which in many places severely limits the capacity of social workers to go a step further and address other types of medically-relevant social needs such as housing, lack of transportation, and food insecurity.<sup>21</sup> To fill this gap, some EDs have experimented with or implemented comprehensive social needs screening and navigation programs in which non-clinical staff or volunteers administer social need screening questionnaires to patients and families and facilitate connections to resources these families may be interested in to fulfill their needs.<sup>22,23</sup>

EDs have begun adding other new programs to address specific social needs and access to care issues. For example, some centers have started COVID-19 vaccination programs, for which ACEP offers a toolkit and other resources on their website, expanding access to vaccines for patients who may not have a primary care physician or another way to discuss vaccine-related questions.<sup>24</sup> Emergency physicians across the country have also brought the Vot-ER program to their EDs, helping to integrate voter registration into health care delivery.<sup>25</sup>

In some cases, new state-wide policies have introduced mandates that EDs offer certain social resources. For instance, in 2019, California passed Senate Bill (SB) 1152, requiring that homeless patients be offered a bundle of resources at discharge from the hospital or ED to ensure their safety. While the passage of the bill has motivated more robust ED screening for homelessness and, in many places, a good faith effort to offer additional resources to homeless patients, the shortcomings of the bill, namely the lack of funding to support housing navigators to continue to work with patients on finding housing after discharge and additional funding for the shelter system, have also been widely recognized and hampered its impact.<sup>26</sup> If future iterations of SB 1152 include additional support, such as a funding mechanism for housing navigation, this legislation could be a model for other states wanting to better support persons experiencing homelessness.

In summary, emergency physicians are becoming increasingly attuned to the social and structural determinants of health and health inequities and their impact on patients in the ED. While the ability to comprehensively address SDoH in the

ED is hampered by funding, many EDs now offer at least some social resources to patients even on a constrained budget.

## Moving Forward

The EMRA Policy Compendium includes a variety of position statements regarding SDoH. EMRA explicitly mentions advocacy priorities that include women's and reproductive health, reforms of the criminal justice system and equitable care for incarcerated patients, firearm safety and injury prevention legislation, health disparities research, increased coverage for mental health disorders, classification of substance use disorder as a chronic and progressive medical condition, and opposition of family separation for undocumented immigrants at national borders.<sup>27</sup> The Policy Compendium also mentions specific EMRA goals for the specialty, including (but not limited to) developing and implementing more curriculum and training on the role of EM in public health, preventive medicine, and social medicine, and creating additional research support for studies on the relationship between SDoH and health outcomes.

The specialty of EM has made great progress in recent years increasing awareness of the role of social and structural factors on health, and yet, additional steps need to be taken for EM to completely fulfill its social mission. Advocates of social emergency medicine and a more holistic approach to care can help by asking for and supporting additional funding for social work and case management support in the ED, helping their EDs strengthen relationships with community agencies offering social resources, researching evidence-based strategies for screening for and addressing SDoH, and continuing to work toward equity in health outcomes for all patients.

## TAKEAWAYS

- Systems of emergency care are evolving to respond more holistically to patient needs, attending to both the immediate medical concern and working in multi-disciplinary teams that include social workers, case managers, other nonclinical staff to identify social determinants of health and facilitate connection with social resources.
- The COVID-19 pandemic exacerbated and laid bare many adverse social determinants of health that will continue to be important issues for advocacy in the future.
- The EMRA Policy Compendium includes a variety of position statements regarding SDoH, which emergency physicians and trainees in EM can refer to for talking points and ideas when discussing potential policies with local, state and federal legislators.



# PHYSICIAN PAYMENT 101

*Nishad Abdul Rahman, MD; Nicholas Rizer, MD; Jordan Celeste, MD, FACEP*

**Physicians generate revenue and earn income based on several encounter-specific factors, including acuity, risk of the presenting condition, the work-up ordered by the physician, and, prior to 2023, the comprehensiveness of charting.**

Physician productivity and subsequent financial compensation is measured in units of productivity known as relative value units, (RVUs), which are influenced by the Resource-Based Relative Value Scale (RVS) Update Committee, called the RUC (referred to as “the Ruck” colloquially.)

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*Changes to physician payment structure will continue over the years to come. Physicians must be at the forefront, ensuring that we create the appropriate financial incentives that will drive a positive future for emergency medicine while minimizing unintended consequences.*

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## Why It Matters to EM and ME

As physicians, we measure our own success on a scale of lives saved and morbidity prevented. Unfortunately, this is not how productivity is calculated by payers for health care services or employers determining physician compensation. To them, it all comes down to dollars and cents, and physician productivity must be calculated using metrics. Physician employers most often delineate financial compensation at least in part based upon RVUs generated, regardless of whether you work for a hospital, a small democratic group, a privately owned company, or a large contract management group. It is critical that every physician understands RVUs to ensure their clinical practice remains economically viable and to establish their own financial well-being.

## How We Got to This Point

The history of physician payments long predates the development of emergency medicine as a specialty. The dominant model of physician payment in the early 20th century relied on direct payments by patients to doctors for the work performed by the doctor.<sup>1</sup> This would form the basis of the fee-for-service model, where separate fees were paid to the physician for each and every service provided. The physician would charge the patient a bill and the patient would

pay to the best of their ability. This model came under increasing scrutiny in the 1910s, when calls for widespread health insurance began to grow. In 1915, the American Association for Labor Legislation (AALL) introduced a compulsory medical insurance draft bill in multiple state legislatures. Initially, the American Medical Association (AMA) House of Delegates expressed support, but by 1920, the AMA was against the measure.<sup>2</sup>

Then, after the stock market crash in 1929, the Great Depression strained industries including the health care sector. Like most organizations in the country, Baylor University Hospital was under tremendous financial stress, with lower payments per patient and fewer patients coming to the hospital.<sup>3</sup> The hospital's administrator decided to counter the lost revenue by securing a steady income stream. In 1929, 1,250 Dallas public school teachers contracted with Baylor University Hospital for 50 cents per month, which secured them up to 21 days of hospitalization per year. The concept of prepaid hospital plans expanded across the country, providing a cash flow that helped keep the hospitals afloat during these lean years and provided security from calamity for customers. These plans were the precursors to today's Blue Cross.

As Blue Cross plans spread, the American Hospital Association stepped in to set guidelines designed to reduce price competition among hospitals. Instead of locking patients into only one hospital, like the 1929 Baylor Plan, open access to multiple hospitals became recommended.

However, Blue Cross plans accounted only for hospital insurance, specifically excluding physician fees, and the AMA continued to oppose compulsory health insurance. The AMA and its members were wary of health insurance during the 1930s, fearing potential for the loss of professional autonomy. This began to change in 1939 as the AMA started encouraging state and local medical societies to offer pre-paid medical insurance plans to cover physician services. Their acceptance was multifactorial: Blue Cross wanted to secure physician services in order to compete with other commercial insurers and offer comprehensive coverage beyond only hospital care, while the AMA wanted to head off potential far-reaching government reform proposals by establishing voluntary insurance options. The physician-organized plans covering physician services would eventually affiliate together and become Blue Shield.<sup>2,3,4</sup>

Regulations during World War II accelerated the adoption of employer-sponsored health insurance plans, including Blue Cross and Blue Shield. As part of the war effort, wage increases were limited to ensure a stable labor force for war manufacturing. While wage negotiations were limited, the federal government did allow employers to offer benefits such as health insurance, which firms used to differentiate themselves and attract workers. While these war-time regulations helped spur the adoption of employer-sponsored health insurance plans, tax regulations rapidly accelerated their development. In 1954, the Internal Revenue

Service ruled that employer contributions to employee health insurance were not part of regular income and hence not taxable. This was a boon for both employers, who could now offer untaxed (and hence essentially subsidized) benefits to attract workers, and health insurers.<sup>5</sup>

The fee-for-service model arose from these early insurers, who would reimburse patients for hospital and physician bills.<sup>6</sup> Medicare and Medicaid built upon the existing chassis of the private fee-for-service structure, with the government paying physicians their usual and customary rates, instead of private third-party insurance companies.<sup>7,8</sup>

Initially administered separately by individual agencies, the Health Care Financing Administration (HCFA) was established in 1977 to coordinate both Medicare and Medicaid.<sup>9</sup> In 2001, as part of efforts to improve and reform the original institution, HCFA was renamed the Centers for Medicare and Medicaid Services (CMS), as it is known today, and charged with three separate goals: first, to ensure Medicare beneficiaries know all of their potential choices including HMOs; second, to administer traditional Medicare; and third, to work with state-administered programs such as Medicaid and the State Children's Health Insurance Program.<sup>10</sup> By the 1980s, concerns regarding the cost of physician payments under the "usual, customary, and reasonable" charge schema developed. Due to concerns over rising health care costs, overvaluing procedures, and misaligned incentives, policymakers sought to develop a more rational payment system. Congress authorized a study by the AMA and Harvard University to determine the 'relative value' of physician services compared to one another, a system that would become known as the resource-based relative value scale (RBRVS).<sup>11</sup> The 1992 Omnibus Budget Reconciliation Act established the RVU, with each physician service assigned a number of RVUs, the basis for Medicare payments to physicians. This has remained the basis for physician payments, whether to physicians themselves or the organizations that employ them, for the overwhelming majority of physicians nationwide, including emergency physicians.<sup>12</sup> The impact of RVUs goes beyond just Medicare patients, as private insurance companies typically base their physician payments on CMS payments.

## **Current State of the Issue**

In practice, how do RVUs work? Every physician encounter and procedure is given a Current Procedural Terminology (CPT®) code. CPT codes are standardized codes that encompass the full range of medical services and procedures developed by the AMA, which allow physicians to use a uniform language to bill for their work.<sup>13</sup> CPT codes also aid in determining reimbursement for a wide variety of physician services. Each CPT code has an associated number of RVUs attributed to it. RVUs are not static, but rather re-established at least every 5 years by CMS, as mandated by federal

law.<sup>14</sup> Physicians have a significant influence over this process through a committee called the RUC. The RUC is a committee of the AMA, composed of 32 total members, with 22 members appointed by national medical specialty societies – including emergency medicine which has one permanent seat on the RUC. ACEP, as the representative of the specialty in the AMA House of Delegates, funds the team that represents the specialty in this venue. There are 4 rotating seats, including 1 seat for a primary care specialty, 2 for internal medicine subspecialties, and 1 other specialty.<sup>15,16</sup> Members of the RUC listen to presentations from specialty advisors, based on survey data, and then vote on proposed RVU values and service times to make their recommendations to CMS. Using the recommendations provided by the RUC, Medicare determines the value of each service or procedure by assigning an amount of RVUs. The RUC recommendations are highly influential on the ultimate compensation decisions made by CMS. According to the AMA, in most years, over 90% of RUC recommendations are adopted by CMS.<sup>17</sup>

There have been concerns that the membership structure of the RUC over-represents specialties, particularly surgical subspecialties, thereby potentially leading to higher values for procedures over cognitive work (such as an office visit). The RUC defines work as “intensity over time”, which is why a high-intensity procedure like endotracheal intubation (code 31500) will have a higher work RVU at 3.00 than a level three ED visit (code 99283) at 1.60. This is why it is important that you capture all of the work that you do in the emergency department setting, whether that be EKG review, suture placement, dislocation reduction, or intubation. Any and all procedures should be documented. In addition to just being good medicine, it is good business and will be expected by your employer.

RVUs comprise three factors: Physician Work + Practice Expense (facility) + Liability Insurance (malpractice). Together, these add to the “Total RVU.” However, RVUs are altered based on the location of practice to adjust for cost of living – called the Geographic Practice Cost Index (GPCI). Finally, when total RVUs have been calculated and adjusted based on the GPCI, they are multiplied by the Medicare conversion factor (CF) to arrive at the final payment. The Medicare CF is updated annually.<sup>18</sup> For 2022, CMS has set Medicare payments at \$34.6062 per total RVU. For example 99285, a common CPT code for high-intensity ED visits, is worth 5.17 RVUs, which would reimburse \$178.91 in 2022.<sup>19</sup>

In emergency medicine, visits are coded with 1 of 5 CPT codes for evaluation and management of the patient based on the intensity of the visit (Level 1, 99281, is the least intense visit possible; level 5, 99285, is the most intense). Intensity represents the amount of work done in a certain amount of time, so high-acuity conditions requiring prompt and complex workups and timely treatment are considered more intense. Billers and coders determine intensity through a combination of the acuity of the patient’s presentation and the complexity of the

medical work-up required to arrive at the diagnosis and treatment provided. This is the payment for the “cognitive” work of emergency medicine.<sup>19</sup>

Physicians are also reimbursed for the “physical” work of emergency medicine. Physicians can be reimbursed for procedures performed, such as intubations, laceration repairs, procedural sedation, and central lines. Most procedures performed in the ED have an associated CPT code and can be reimbursed separately.<sup>19</sup> Additionally, ultrasound exams and your independent interpretation of diagnostic studies (eg, ECGs) can be billed using procedure codes.<sup>20</sup> Of course, the work of each procedure must be appropriately documented to generate RVUs.<sup>19</sup>

Additionally, physicians may bill for critical care time when providing care for a patient with a critical illness. A “critical illness” is a presentation with a high probability of imminent or life-threatening deterioration in condition. These codes are unique in that they are time-based, allowing emergency physicians to bill for the amount of time they spend in the management of these patients. The first 30 to 74 minutes of care are coded with CPT code 99291, and each additional 30-minute interval of time after 105 minutes can be separately billed and reported using 99292. Of note, critical care time excludes time spent on separately billable procedures as well as teaching time.<sup>21</sup>

However, payments are not as simple as coding and billing for a set CPT. The documentation created in the medical record by the physician needs to support the code being billed by demonstrating the intensity of the medical decision-making (MDM) involved in patient care.<sup>19</sup>

### **Assessing the intensity of the MDM consists of 3 components:<sup>22</sup>**

1. Number and Complexity of Problems Addressed
2. Amount and/or Complexity of Data to be Reviewed and Analyzed
3. Risk of Complications / Morbidity / Mortality of Patient Management

Level 1 visits (99281) are defined as visits for which the evaluation and management of the patient may not require the presence of a physician or qualified health care professional, while Level 5 visits (99285) are defined as those that require high-intensity medical decision-making. Levels 2-4 are visits requiring straightforward, low, and moderate medical decision-making, respectively.<sup>19</sup>

The “Number and Complexity of Problems Addressed” component attempts to quantify the overall complexity of the medical problems identified during a visit. Essentially, higher acuity problems and multiple problems qualify for increased complexity (see Table 5.1).

The “Amount and/or Complexity of Data to be Reviewed and Analyzed” section quantifies how much work went into interpreting the data for a visit. There are 3 levels of complexity (Limited, Moderate, Extensive) in this component. Each

level of complexity has requirements for the number and categories of data that must be documented. Data is organized into 3 categories.

- **Category 1** consists of ordering tests, interpretation tests, reviewing outside documents, orders, and/or obtaining history from non-patient sources, who are designated as independent historians.
- **Category 2** is your independent interpretation of tests such as EKGs, ultrasound, or a chest X-ray as long as you do not bill it separately (ie, you cannot bill for your interpretation of an EKG and include it in your complexity score).
- **Category 3** includes instances when you discuss interpretation or management of a test with an “external physician/other appropriate source,” which is most often a consultant or admitting physician in emergency medicine.

The “Risk of Complications / Morbidity / Mortality of Patient Management” component attempts to quantify the potential seriousness of consequences of patient management decisions. There are four tiers: minimal, low, moderate, and high. The decision to administer medications or perform bedside procedures can contribute to risk. Additionally, social determinants of health that affect treatment, if appropriately documented, can also increase the risk tier. Generally, more involved procedures or management decisions contribute to an increased risk tier.

To determine the appropriate MDM complexity, each of the 3 sub-components is assigned the appropriate score. Each MDM has corresponding requirements for each sub-component. To qualify for a particular MDM complexity, a physician must meet the required level in 2 of 3 of the sub-components. The visit is billed at the highest MDM complexity for which it qualifies.

Under the system that had been in place since 1995, there was a required minimum documentation for the history of present illness, review of systems, past medical history, social and family history, and review of systems to qualify for each E&M code. These imposing requirements will no longer be mandatory under the new 2023 guidelines. Instead, billing code selection will be based only on medical decision-making. However, a medically appropriate history and/or physical exam should still be documented, which will help guide coders and auditors to understanding the complexity of the medical issues being addressed as well as provide clear communication to our medical colleagues.<sup>22</sup>

A high-intensity diagnosis alone is not enough to qualify for a high-intensity visit; the documentation created by the emergency physician must capture enough of the work and medical decision-making that contributed to the patient’s care to justify the diagnosis. Insurance companies will “downcode,” or decrease the billing level and compensation provided, if the available documentation is insufficient to justify the code billed.<sup>19</sup>

**Table 5.1. Medical Decision-Making**

Level of MDM <small>Based on 2 of 3 elements</small>	Number & Complexity of Problems Addressed	Amount/Complexity of Data to be Analyzed	Risk of Complications and/or Morbidity/Mortality
99281	N/A	N/A	N/A
99282	Straight-forward <b>Minimal</b> • 1 self-limited/minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostics/treatment
99283	Low <b>Low</b> • 2+ self-limited/minor problems • 1 stable chronic illness • 1 acute, uncomplicated illness or injury • 1 stable, acute illness • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	<b>Limited</b> ( <i>must meet requirements of at least 1 of these 2 categories</i> ) <b>Category 1: Tests &amp; documents</b> • Any combination of 2 of these: – Review of prior external note(s) from each unique source* – Review of result(s) of each unique test* – Ordering of each unique test* <b>Category 2: Assessment requiring independent historian(s)</b> <i>(For the categories of independent interpretation of tests &amp; discussion of management or test interpretation, see 'Moderate' or 'High')</i>	Low risk of morbidity from additional diagnostics/treatment
99284	Moderate <b>Moderate</b> • 1+ chronic illnesses with exacerbation, progression, or side effects of Tx • 2+ stable chronic illnesses • 1 undiagnosed new problem with uncertain diagnosis • 1 acute illness with systemic symptoms • 1 acute complicated injury	<b>Moderate</b> ( <i>must meet requirements of at least 1 of 3 categories</i> ) <b>Category 1: Tests, documents, or independent historian(s)</b> • Any combination of 3 of these: – Review of prior external note(s) from each unique source* – Review of result(s) of each unique test* – Ordering of each unique test* – Assessment requiring independent historian <b>Category 2: Independent interpretation of tests</b> • Independent interpretation of test performed by another clinician (not separately reported) <b>Category 3: Discussion of mgmt or test interpretation</b> • Discuss mgmt or test interpretation w/ external clinician/source (not separately reported)	Moderate risk of morbidity from additional diagnostics/treatment  <i>Examples only:</i> • Rx drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
99285	High <b>High</b> • 1+ chronic illnesses w/ severe exacerbation, progression, or side effects of Tx • 1 acute or chronic illness/injury that poses a threat to life or bodily function	<b>Extensive</b> ( <i>must meet requirements of at least 2 of 3 categories</i> ) <b>Category 1: Tests, documents, or independent historian(s)</b> • Any combination of 3 of these: – Review of prior external note(s) from each unique source* – Review of result(s) of each unique test* – Ordering of each unique test* – Assessment requiring independent historian <b>Category 2: Independent interpretation of tests</b> • Independent interpretation of test performed by another clinician (not separately reported) <b>Category 3: Discussion of mgmt or test interpretation</b> • Discuss mgmt or test interpretation w/ external clinician/source (not separately reported)  <i>*Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1.</i>	High risk of morbidity from additional diagnostics/treatment  <i>Examples only:</i> • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital-level care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances

MDM grid courtesy of:  

**American College of  
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ADVANCING EMERGENCY CARE 

## Moving Forward

The EMRA Representative Council has voted repeatedly to enhance trainees' understanding of the factors affecting their livelihood. Two policies in particular are key:

- **Section VI – Resident and Medical Student Education, IV. Financial Literacy Among Residents**  
EMRA will advocate for further resources and research will be allocated toward improving financial literacy among residents.<sup>23</sup>
- **Section VI – Resident and Medical Student Education, VIII. Resident Indebtedness**  
The cost of medical education is ever-increasing, and medical students are entering residency with increasing levels of debt. This substantial education debt often impacts the residency experience as residents attempt to begin repayment on these loans. Efforts should be made to increase the tax deductibility of student loan payments, reinstate residency loan forbearance and deferment, and recognize emergency medicine as eligible for state and federal loan relief programs.<sup>23</sup>

It is crucial that physicians continue advocacy efforts concerning payment models, as these have a significant impact on compensation. There have been ongoing conversations about potential new models of compensation, known as Alternate Payment Models (APMs). This has been spurred by CMS' ongoing movement away from fee-for-service compensation and toward value-based care, rewarding better care and better outcomes.<sup>24</sup>

ACEP has put forth an EM-specific APM called the Acute Unscheduled Care Model (AUCM), which represents a step closer to true value-based care.<sup>25</sup> AUCM highlights the unique ability of the ED, with the appropriate tools, resources, and data, to safely discharge patients instead of having to admit them, and thereby realize significant health care savings. AUCM increases payments towards emergency physician groups who successfully reduce Medicare expenditures by reducing avoidable hospital admissions, improving post-discharge services, while still avoiding post-discharge adverse events.<sup>26</sup> Potential adoption or adaptation of this plan remains under the discretion of the Centers for Medicare and Medicaid Innovation (CMMI).<sup>27</sup> While this model offers an opportunity to compensate emergency physicians who provide high-quality and lower-cost care, it is still built on the foundation of fee-for-service billing.

Changes to the current payment structure will be implemented over the years to come. Physicians must be at the forefront, ensuring that we create the appropriate financial incentives that will drive a positive future for emergency medicine while minimizing unintended consequences.

## TAKEAWAYS

- Physicians are paid in units of productivity known as RVUs that are influenced by an organization called the RUC.
- Level of intensity and thus reimbursement for ED visits is determined by a combination of their level of acuity, how much workup is necessary, and the risk inherent in the patient's presentation.
- Emergency physicians are also reimbursed separately for procedures we perform.
- The future of physician payments during the transition from fee-for-service to value-based care remains uncertain.
- Physicians must be at the forefront of policy discussions concerning their compensation.





# PATIENTS AS PAYERS

Kirstin Woody Scott, MD, MPhil, PhD; Pranav Kaul, MD;  
Michael Granovsky, MD, CPC, FACEP

**This chapter explores the complexities of the U.S. health care system, the mechanisms through which patients bear financial responsibility for the cost of their care,** and also features some of the ongoing debates relevant to patients who wish to seek emergency care without fear of costs – including the challenges of being uninsured or underinsured when emergencies happen.

## Why It Matters to EM and ME

The emergency department (ED) is the safety net of our health care system, seeing all patients regardless of their ability to pay.

However, patients are increasingly worried about the cost of care, especially as it relates to acute, unscheduled health events. This has numerous implications for emergency physicians and their practice, both clinically and financially. Unlike other segments of the health care system, the ED is unique in that all patients receive treatment regardless of their ability to pay at the point of service, in accordance with the federal law known as EMTALA (see Chapter 1 for details). Consequently, emergency physicians deliver the largest amount of “charity care” compared to any other specialty! This model of service-before-payment may surprise patients who receive bills for their ED care long after the event took place, especially if they incorrectly assumed that a particular service was covered by their insurance plan. This has translated into heightened public awareness and concerns about ED costs, which has led to various state and national legislation, such as the No Surprises Act of 2020. Further, national and state emergency medicine organizations continue to face threats to what is known as the “prudent layperson” standard, which contends that physicians should be reimbursed for ED visits regardless of whether the patient was ultimately

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*Various forms of cost-sharing, regardless of insurance status, can have a direct impact on the care that we provide ED patients. This can take the form of patients dreading the cost of the ED before they seek care, hesitating to seek care, and then – if they do seek care – feeling hesitant to accept the recommendations made by their emergency physician due to financial worries.*

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diagnosed with a medical emergency. Insurers sometimes retroactively deny these claims, despite very concerning presenting symptoms - leaving patients to solely cover the costs of their emergency care. Regardless of the cause, given the mechanisms by which patients are payers of health care services in the U.S. health care system, this can heighten patients' fears about the cost of ED care in a way that can impact care-seeking behavior; patients may delay or even forego needed emergency medical care altogether due to fears of unpredictable or high costs.

## **How We Got to This Point**

The U.S. health care “system” is complex, consisting of a patchwork of payers, physicians, hospitals, and others in the health care chain. Though the system has a number of strengths in terms of innovation and technological advancements in medicine (especially for those who can afford quality care), its complexity leads to inefficiencies that can be challenging for patients to navigate.<sup>2,3</sup>

Health care in the U.S. is the most expensive in the world (amounting to \$4.1 trillion dollars in 2020).<sup>4</sup> In spite of its strengths, the U.S. system's health outcomes are not commensurate with the expense paid compared to similar nations.<sup>5</sup> While spending trillions, the U.S. does not guarantee access to health care to all of its citizens and experiences myriad challenges with financing the high cost of care.<sup>5,6</sup>

Uneven access to health coverage in the U.S. is relevant to emergency physicians because the ED has been characterized as the “safety net” for millions of Americans.<sup>7</sup> Everyone who arrives at the ED is entitled to a medical screening exam and to stabilizing treatment regardless of ability to pay. This requirement has been codified in federal law since 1986 for all hospitals reimbursed by Medicare, which is the largest payer of health care services in the U.S. and thus has immense influence on setting payment standards.<sup>8</sup> This EMTALA requirement does not apply to outpatient clinics or ambulatory centers, or even to the Veterans' Affairs Hospitals, as they do not rely on Medicare funding. Because of EMTALA, patients encounter no financial barriers to initially accessing emergency care unlike other clinical settings. However, patients are still ultimately responsible for the expenses incurred during an ED visit or subsequent hospitalization. This logistical mechanism of patients paying after an ED visit set the stage for why surprise billing, which is explained further below and in Chapter 8.

This chapter serves as a primer to explain that patients are still the payers in this complex system. To understand this, it is helpful to keep in mind three main categories of “payers” when you examine who is footing the bill for the trillions of dollars that circulate through the current U.S. health care system:

- Private payers (eg, commercial insurance - potentially obtained through one’s employer or through the individual market, such as HealthCare.gov Marketplaces, TRICARE, worker’s compensation). Commercial payers may be either for-profit or non-profit.
- Public payers (eg, Medicaid [a state-federal partnership for primarily low-income individuals]), Medicare (for patients aged 65 and older or those with end-stage renal disease, or amyotrophic lateral sclerosis), Medicare Advantage (a privatized version of Medicare), other federal/state/local (eg, county hospitals and health systems, and Veterans Affairs).
- Individuals paying out-of-pocket payments (eg, those who are insured have out-of-pocket payments for health care such as deductibles, copays, or coinsurance as well as the uninsured “self-pay” patients who must pay all health care expenses out of pocket)

All patients - regardless of insurance status - are “payers” of health care services in some way. As such, it is helpful to understand how many individuals in the U.S. system are uninsured and thus have no financial risk protection from health care costs, especially in cases of acute, unscheduled care. As of 2021, more than 28 million Americans were uninsured, representing 8.8% of all Americans and 10.5% of those under the age of 65.<sup>11</sup> While insurance coverage provisions such as the dependent coverage expansion, expansion of Medicaid, and creation of the health insurance marketplaces that were included in the Patient Protection and Affordable Care Act (ACA) markedly reduced the uninsurance rate to all-time historic lows, coverage gaps still remain.<sup>11-13</sup>

When someone is uninsured (ie, “self-pay” patient), they have no contract with an insurer in place to protect them from the full charges associated with a particular health care service. Though uninsured patients do not pay monthly insurance premiums, their lack of insurance coverage means they are often subjected to list prices for the services they receive. Uninsured patients consistently face higher bills for health care services relative to other patients, including for ED care, and may be at risk of financial peril as a result.<sup>15-17</sup>

However, the 91% of Americans who currently have some form of health insurance are also still “payers” through various forms of cost-sharing. First, all insured patients pay a monthly premium (if insured through their employer, that premium cost may also be shared by the employer). Additionally, patients accrue

financial responsibility at the point of service in the form of deductibles, co-payments, and co-insurance, which are defined as follows:

- Deductibles are the amount to be paid by the insured before most services are covered by their insurance plan.
- Copayments are a fixed amount paid by the insured at time of service.
- Coinsurance is the percentage of service costs paid by the insured after the deductible is met.<sup>18</sup>

The mechanism of cost-sharing varies dramatically by insurance type, but can be applicable to both public and private insurance plans.<sup>19,20</sup> For example, each state can opt to include limited premiums or enrollment fees for certain low-income patients who qualify for Medicaid in an attempt to enforce some “personal responsibility” for paying for health care.<sup>19</sup> However, research suggests deleterious effects of these cost-sharing mechanisms on low-income Medicaid enrollees, including evidence that out-of-pocket payments are associated with barriers to obtaining coverage, reductions in necessary care, and lack of visible cost savings to the state.<sup>21</sup>

Even insured patients who receive “in network” services face some degree of out-of-pocket costs for their health care. With rising health care costs and rising deductibles, many of these patients’ out-of-pocket contributions have increased over time.<sup>22</sup>

## **Current State of the Issue**

The unique nature of emergency medicine’s ethical and legal commitment to not delay screening or treatment of emergencies due to one’s ability to pay at the point of service means that no payment is required up front by the patient in an ED. Given that the ACA made emergency services an “essential health benefit,” there is an expectation that it is essential and yet there is much variation in the specifics of how much insurance pays versus how much the patient pays once the service is provided.<sup>23,24</sup>

Americans have consistently ranked health care costs as a top financial worry.<sup>25</sup> Data from the 2020 National Health Interview Survey showed that 1 in 11 Americans reported delaying or forgoing medical care due to health care costs, with these delays even more pronounced among low-income or uninsured Americans.<sup>26</sup> Specifically, nearly 1 in 3 (30%) of uninsured Americans reported either forgoing or delaying care due to costs.<sup>26</sup> However, even patients with insurance report concerns with medical bills. In December 2021, nearly half of Americans (46%) reported difficulty with paying out-of-pocket medical bills that were not covered by their insurance.<sup>25</sup>

This mixture of complexity, confusion, and concerns about costs overall, helped to fuel rising public attention and outcry on the topic of out-of-network balance billing ( or “surprise” billing) among patients with commercial private insurance.<sup>27,28</sup> Balance billing is not permitted for Medicaid or Medicare. Though this practice was by no means limited to the specialty of emergency medicine (ie, the possibility and practice of balance billing exists across all specialties, including anesthesiology and primary care), prominent media coverage featured many cases of this happening in the setting of a patient being treated for a medical emergency.<sup>29</sup>

Due to challenging practices by some payers, some ED physicians have not been able to remain contracted as an “in-network” physician and thus are characterized as “out-of-network.”<sup>30</sup> This exposes patients who are facing a medical emergency, even if located physically in an “in-network” hospital, to medical care by a physician who is not covered by their insurance contract. A 2019 study documenting trends of out-of-network billing in both EDs and inpatient hospitalizations from 2010-2016 showed this practice was happening more frequently and resulted in higher bills for patients over time.<sup>31</sup> Given the mission of the ED to care for anyone at any time and regardless of ability to pay, this issue of surprise billing led the specialty of emergency medicine to support patient protections to correct this policy flaw.<sup>32,33</sup>

In early 2020, 65% of Americans reported they worried about unexpected medical bills.<sup>34</sup> The majority of Americans supported federal action to protect patients from surprise medical bills, including when being taken to the ED by an out-of-network ambulance, when being taken to an out-of-network hospital in the case of an emergency, or when being treated by an out-of-network physician even at an in-network hospital.<sup>34</sup> Responding to this outcry, Congress passed the No Surprises Act in 2020, which went into effect as of Jan. 1, 2022.<sup>35,36</sup>

Increasing evidence exists to show that out-of-pocket costs are on the rise for all patients, regardless of insurance status. Given the ED’s distinct role as a true safety net for uninsured patients, it is important to examine the evidence of the financial impact that emergencies can have on uninsured patients. Studies focusing on patients hospitalized for emergency conditions such as traumatic injury and acute coronary syndrome suggest that 80-90% of uninsured patients are at risk of receiving a bill that would qualify for what the World Health Organization has defined as a catastrophic health expenditure,<sup>37-39</sup> defined as annual out-of-pocket health care spending that is greater than 40% of one’s post-subsistence (paying for housing and food) household income or 10% of one’s total annual household income.<sup>37,39</sup> This measure of financial toxicity of health care was also the subject of a study focused on uninsured ED patients, which found that 1 in 5 uninsured patients were at risk of receiving a bill that met catastrophic health expenditure thresholds for a single treat-and-release ED visit.<sup>17</sup>

Though this risk of financial toxicity may be a predictable challenge of the U.S. health system for those who lack insurance, underinsurance also exposes patients to similar risks.<sup>40</sup> Simply put, many insured Americans are struggling to afford health care, including some who are having difficulty paying for their hospitalizations after COVID-19.<sup>41</sup> An important trend to consider when it comes to patients as payers is the growth of high-deductible health plans (HDHP). These insurance products were created with an intent to make patients more cost-conscious when seeking care.<sup>42</sup> HDHPs are attractive to prospective buyers because they have lower premiums than traditional health insurance products. Between 2010 and 2020, there was an estimated 18% growth in the proportion of covered workers enrolled in an HDHP.<sup>43</sup> As expected, those enrolled in HDHP insurance products have higher deductibles than those in other traditional insurance plans, such as health maintenance organization (HMO) or preferred provider organization (PPO) products.<sup>43</sup> HDHPs can be paired with Health Savings Accounts (HSAs) that allow money used for certain medical payments to be exempt from federal taxes.<sup>44</sup>

Yet, if patients with a plan that could be categorized as an HDHP have any sort of emergency, they must pay for all health care expenditures until they meet the deductible. As of 2022, the Internal Revenue Service defines a HDHP as any plan with a deductible of \$1400 for an individual (with yearly out-of-pocket max no more than \$7050 for in-network services) or a deductible of \$2800 for a family insurance plan (with a yearly out-of-pocket max no more than \$14,100 for in-network services).<sup>44</sup> The average annual deductible was \$2454 for HSA-qualified HDHPs.<sup>43</sup> While some customers opt for these high-deductible plans in order to pay lower monthly premiums, the tradeoff is inherent downstream risk. Recent studies have suggested that HDHPs with HSAs are a tax break benefitting healthier and wealthier populations.<sup>51</sup> However, nearly two in three households report not having enough assets to pay for the deductible of some of the HDHP plans.<sup>40</sup> When an emergency happens, patients can feel especially vulnerable since the cost of emergency care may require spending up to the top end of a “high” deductible.

Another critically important payer of ED care is Medicaid. Evidence suggests that those under the age of 65 with Medicaid are twice as likely to go to the ED for care relative to the privately insured.<sup>45</sup> However, there have been many policies affecting this diverse program managed by each state that can lead to cost sharing among Medicaid patients. For example, states can impose higher copayments for Medicaid patients when they have sought emergency care in situations that retroactively are later determined to not have been a medical emergency. This is an attempt by state agencies to reduce “non-emergency” use of the ED.<sup>19</sup> Another important issue is that 69% of Medicaid patients are in

comprehensive managed care contracts.<sup>9,54</sup> **As of 2019, the lion's share of these contracts were provided by 16 parent firms, 7 of which are publicly-traded, for-profit firms.**<sup>9</sup> This level of consolidation and management by for-profit companies has the potential to negatively influence reimbursement trends for Medicaid as managed care firms seek to increase their profit. It is therefore important that emergency physicians are aware of trends affecting Medicaid reimbursement rates in their state as well as policies that might increase patients' likelihood of cost sharing for ED care.

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*It is no surprise that some patients avoid seeking emergency care when they fear crippling medical expenses as a result. As emergency physicians, we play a critical role in advocating for policies that ensure that patients do not hesitate to seek emergency care for anything, anytime, and regardless of ability to pay.*

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Privately insured patients have also faced many challenges of being billed for their ED visit after it was retrospectively deemed to be “not an emergency.” Some insurers have frequently denied claims for ED visits based on final diagnosis rather than the presenting complaint, which violates the “prudent layperson” standard (a requirement that insurers must pay for emergency services based on presenting symptoms (eg, chest pain) rather than the final determined diagnosis (eg myocardial infarction vs. musculoskeletal pain)).<sup>46,47</sup> In just one example, UnitedHealthcare announced a policy shift to “crack down” on non-emergent emergency room claims.<sup>48</sup> This shift may influence patients to pause before seeking needed emergency care, which may result in more complex and expensive presentations of illness.

Cost sharing – regardless of insurance status – can have a direct impact on the care that we provide for patients in the emergency department. This can take the form of patients having fear about the cost of the ED before they seek care, hesitating to seek care, and then – if they do seek care – feeling hesitant to accept the recommendations made by their ED physician due to fear of cost. This presents a unique threat to the therapeutic alliance between patients and their physicians. Understanding how patients pay for health care matters to those providing it.

## **Moving Forward**

Patients will continue to play a key role as “payers” of emergency care. Yet the degree to which they do so in such an expensive system, as well as confusion about what insurance protection actually means to their own pocketbooks, will continue to be the source of much policy debate.

The substantial gains in health insurance coverage to millions of Americans since the ACA was signed into law have helped to reduce the likelihood that ED

patients have no form of financial protection when receiving emergency care. These coverage gains are aligned with the American College of Emergency Physicians statement: “ACEP believes all Americans must have health care coverage.”<sup>52</sup> However, coverage gains have been uneven. Specifically, millions of Americans would be eligible for Medicaid under federal law, but 12 states (listed below, as of November 2022) have not opted to expand coverage for a variety of reasons.<sup>53</sup>

**Table 6.1. Medicaid Expansion as of November 2022**

States that Have Not Expanded Medicaid as of November 2022	
Alabama	Florida
Georgia	Kansas
Mississippi	North Carolina
South Carolina	South Dakota*
Tennessee	Texas
Wisconsin	Wyoming

*\* In November 2022, South Dakota voters passed a ballot initiative to expand Medicaid; implementation is planned for July 2023.*

Beyond advocacy for expanding insurance coverage, another area of advocacy related to patients as payers of ED care is the ongoing threats to the “prudent layperson” standard. ACEP and EMRA have a strong history of advocacy related to this topic. Private insurers such as UnitedHealthcare and Anthem have attempted to implement policies that shift emergency care reimbursements from “complaint-based” to “diagnosis-based.” When Anthem Blue Cross Blue Shield, one of the nation’s largest private insurers, introduced these policy changes in 2017, ACEP alongside other physician groups sued them for violation of the prudent layperson standard as well as the Civil Rights Act.<sup>55,56</sup> Ultimately, in 2022, the insurer discontinued their “avoidable ER” program and ACEP and the other groups settled and withdrew their lawsuit, having successfully protected the prudent layperson standard .

Another domain of ongoing policy interest and further advocacy are national and state initiatives designed to improve health care price transparency, thereby improving a patient’s ability to know how much something costs before they obtain care. For instance, the Fair Health Consumer Website serves as a resource for patients to look up the approximate cost of services at particular institutions and provide guidance on how to read one’s medical bill. CMS also recently implemented a new rule requiring all hospitals in the United States to list prices publicly for the most common services as of Jan. 1, 2021, but compliance with this new rule has been uneven.<sup>57</sup> In June 2022, two Georgia

hospitals were the first institutions to be fined under this new policy, owing over \$1 million combined for price transparency violations.<sup>58</sup> While these resources may be helpful for someone choosing a hospital for an elective procedure, it is doubtful that patients can or should shop for care while experiencing a medical emergency.

Taken together, the structure of the U.S. health system places patients in a challenging position as payers of health care. Patients are both uncertain exactly how much something costs or what they will be expected to pay out of pocket after an emergency happens. Innovations in insurance models and care delivery continue to promote the concept of patient as consumer, yet people are placed in a marketplace with little to no transparency, a complex bureaucracy and regulatory environment, and a constantly changing landscape. It is no surprise that some patients avoid seeking emergency care when they fear crippling medical expenses as a result. As emergency physicians, we play a critical role in advocating for policies that ensure that patients do not hesitate to seek emergency care for anything, anytime, and regardless of ability to pay.

## TAKEAWAYS

- The U.S. health care system is both expensive and extremely complex, consisting of a patchwork of payers, physicians, and hospitals that can be confusing for patients to navigate.
- Patients are key payers of health care in the U.S. system.
- Since the passage of the ACA the number of uninsured Americans has dropped substantially
- Coverage gains due to the ACA have been uneven and incomplete especially due to incomplete expansion of Medicaid.
- Patients are worried about the cost of health care, including ED care, regardless of insurance status.
- Health care costs have the potential to impact the physician-patient therapeutic alliance as patients may be hesitant to receive recommended care due to fear of unknown costs.
- Safety-net and life-saving emergency care in the ED is both legally required by EMTALA and medically necessary yet patients frequently face enormous cost-sharing burdens through various mechanisms such as “surprise bills,” lack of price transparency, narrow networks, and insurance company violations of the “prudent layperson” standard.





# TAKING THE FREE MARKET OUT OF HEALTH CARE

Corinne Rezendes, DO; Sahar Rammaha; Jordan M. Warchol, MD, MPH, FACEP

**As emergency physicians, we are impacted by health care consolidation within the market, including mergers or acquisitions and affiliation agreements between different entities.** These mergers can lead to the closure of facilities, changes in contracts, and change in market competition. Small private practice groups are becoming scarce as physician groups merge or are bought and integrated with hospitals and health systems.<sup>1</sup> The driver behind consolidation is that it carries the potential to enhance coordination of care and cut costs; however, there is also a reduction in competition, which often causes higher prices. Physician groups face challenges in negotiating for fair compensation when large insurers dominate the market in their geographic areas.

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*Horizontal and vertical integration is creating widespread health care consolidation, which leads to market distortions on various levels that affect both consumers and physicians.*

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## Why It Matters to EM and ME

Years ago, a graduating EM resident would often join a private group that had contracts with hospitals to staff emergency departments. Now a graduating physician is more likely to join a hospital or health system that is a product of a merger or exclusive collaboration between a previously independent physician group and hospital. The labor-related impacts of these mergers on emergency physicians is slowly becoming better understood and will continue to be a point of interest in the future.

## How We Got to This Point

The U.S. health care system has prided itself on choice and competition, two essential ingredients to a functioning private market. In other words, the capitalist principles that the non-health care sector enjoys should be reflected in the U.S. health care system in order to generate innovation and lower prices. In this vision, patients, as consumers, have the freedom to choose their

doctors, hospitals, and pharmacies. Currently these “choices” are severely restricted, as they are entirely dependent on the patient’s insurance. Simply put, insurance companies pay all or part of a bill for health care provided to the patient (aka consumer). As a result, the market dynamics seen in other sectors of the economy do not apply. The buyer and seller are no longer the doctor and patient, but instead the consumer and their insurance company and the insurance company and providers of health care.

## Current State of the Issue

### Free Market in Health Care

In order to understand the structure of health care, there are a few terms we need to define in the current market. Health care services (hospital stays, professional services, pharmaceuticals, and medical devices) are the commodities that are being provided to consumers, or patients. The providers in this case are physicians and supporting institutions. Insurance can be thought of as a third-party intermediary that oversees the payment for said transaction. In most cases, the insurance company will have a negotiated fee it is willing to pay the providers for the services provided to the patients.<sup>1</sup> The “free market” allows for significant price variation for services between hospitals and insurers as they determine the prices.<sup>2</sup>

### Consolidation

Consolidation within health care has been ongoing in the United States for quite some time. These consolidations have and will continue to change the health care market, as groups that previously competed merge to become a single entity.<sup>1</sup> Consolidations have been both horizontal and vertical. **Horizontal consolidation** happens when two entities in the same line of work combine: hospitals acquiring other hospitals, physician groups joining with other physician groups, or two insurers becoming one company. As of 2013, 60% of U.S. hospitals were part of a larger health system.<sup>1</sup> In recent years, these horizontal integrations have been extensively investigated due to the very real concern that physician groups joining with competitors in concentrated markets could lead to decreased competition and higher prices.<sup>3</sup> **Vertical integration** occurs when two entities in different areas of health care combine, such as when insurers combine with health systems or hospitals merge with physician groups.<sup>4</sup> Between 2014 and 2018 there was an 89% increase in hospital and health systems becoming owners of physician practices.<sup>5</sup>

Consolidation is predominantly occurring because it increases the negotiating power of the large, consolidated health care entity.<sup>1</sup> The insurance companies and provider groups negotiate with each other, and both are looking to acquire leverage in order to get the most beneficial contracts possible. Additional reasons for consolidation include cost savings due to efficiencies of scale,

improved quality of care by improved integration and care coordination, and access to advanced technology.<sup>1</sup> The Affordable Care Act (ACA) encouraged vertical consolidation with the creation of Accountable Care Organizations, which heavily incentivize care coordination. These larger, vertically and horizontally integrated health systems can arguably be more efficient, offer more opportunities, and – in theory – decrease costs. However, a RAND study found that a physician organization being affiliated with a health system did not reliably predict an increase in care quality or efficiency.<sup>4</sup>

As insurance companies also consolidate, the consequences of a decrease in available insurers in a given geographic area must be considered. The National Bureau of Economic Research found that adding just one more insurance company to a market caused a reduction in premium prices of 4.5%.<sup>6</sup> This alone would bolster the argument that insurance companies mergers are not in the consumer's interest.

Insurers argue they are being driven to consolidate because changes legislated in the ACA are decreasing their profit margins. Unlike before the passage of the ACA, insurers cannot deny patients coverage due to pre-existing conditions and limits are set on the percentage of premiums that insurers can take for profit and “administrative expenses.”<sup>7</sup>

Others argue that the ACA is not entirely to blame, as demonstrated by the fact that consolidations have been happening for many years, including those that occurred well before the ACA was signed into law.

While the power of the government to control health care consolidation has limitations, President Joe Biden issued an executive order stating it would be the policy of the administration “to enforce the antitrust laws to combat the excessive concentration of industry, the abuses of market power, and the harmful effects of monopoly and monopsony — especially as these issues arise in... health care markets (including insurance, hospital, and prescription drug markets).”<sup>8</sup> States also have a role to play in regulating mergers and acquisitions. State attorneys general can improve information sharing across departments and with the federal government to ensure that potentially anticompetitive mergers are reviewed, and states can use litigation to challenge anticompetitive behaviors by large health care organizations that violate state law.<sup>9</sup> Washington State recently required that all potential mergers involving a hospital or physician group be sent to the attorney general for review.<sup>9</sup>

Multiple large health care mergers have occurred in recent years. In 2018, Aetna and CVS combined in a \$69 billion merger of Aetna's insurance business and CVS' pharmacy business.<sup>10</sup> This merger was not only horizontal, as the two companies provided the same services in Medicare Part D and pharmacy benefit management (PBM) services, but also vertical, as Aetna previously purchased

services (PBM and pharmacy) that CVS sold. The AMA opposed the action out of concern that it would have negative consequences for patients and physicians, as did several states, which changed some of the terms of the merger, although the deal still went forward.<sup>11</sup> In 2019, UnitedHealth Group acquired DaVita Medical Group (not including their dialysis business) in a \$4 billion deal. This merger drew scrutiny from the Federal Trade Commission (FTC), particularly because of the potential for a monopoly in the Las Vegas area. For the deal to move forward, the companies needed to divest themselves of a DaVita health care provider organization in Nevada.<sup>12</sup> In 2022, the FTC sued to block two different hospital mergers in an effort to enforce competition laws, consistent with Pres. Biden's executive order.<sup>13</sup>

Many emergency physicians are concerned that health care consolidation will increase costs of care while decreasing physician bargaining power and independence of practice. MedPAC concluded in its 2020 report that hospital consolidation is leading to higher commercial prices and higher costs to patients without definitive evidence of an improvement in care.<sup>14</sup> Consolidation between employers of emergency physicians is another area of concern in our specialty. The number of emergency physicians working in large, national groups increased from one in seven in 2012 to one in four in 2020.<sup>15</sup> In a 2022 letter to the FTC, ACEP President Gillian Schmitz stated that, "While there are some benefits to acquisitions and mergers, including the ability for EM practices to stay profitable and negotiate fairly with insurance companies, the potential anti-competitive labor-related effects must not be ignored—since they could impact wages, non-cash benefits, right to due process, autonomy for medical decision-making, and the ability to serve patients."<sup>16</sup>

## **Effects on Individual Employment**

Health care consolidation affects physicians' individual employment options as well, especially when health care systems force employees to agree to draconian non-compete clauses. In 2023, the FTC proposed a ban on non-compete clauses in all employment contracts (across all sectors), an act vigorously supported and closely watched by ACEP as the rulemaking process continues.<sup>17,18</sup>

## Moving Forward

Emergency physicians should advocate for the FTC and DOJ to continue to investigate mergers and consolidations of physician employers with guidelines that address labor-related impacts including anti-competition, wages, right to due process, autonomy for provider medical decision-making.<sup>16</sup> Mergers and consolidations that create insurer monopolies should also be investigated, as physicians must retain sufficient negotiating power to ensure fair compensation for services provided to patients.

Individual physicians can advocate in a variety of ways. Letters can be written to elected representatives to ask for or encourage a FTC or DOJ review, and physicians can submit comments directly to the FTC or DOJ for ongoing reviews.

### TAKEAWAYS

- Horizontal and vertical integration is creating widespread health care consolidation, which leads to market distortions on various levels that affect both consumers and physicians.<sup>1,3,15</sup>
- Emergency physicians can advocate for the FTC and DOJ to investigate mergers and acquisitions which may lead to abuses of market power, whether the merging entities are physician employers or insurance companies.





# THE NEW REGULATED UTILITY: PHYSICIANS

Saumya Singh, MD; Ashley Tarchione, MD; Jasmeet S. Dhaliwal, MD, MPH, MBA

**While a hospital may be considered in-network for insurance, certain providers or services within that hospital may still be considered out-of-network (OON). Balance billing is the discrepancy between these entities.** If a patient's care involves an out-of-network provider or service, insurance will not cover the entire cost of care. The patient may then be billed for the remaining balance, hence the term "balance bill," often referred to in the media as "surprise billing." Even in the event that a patient has met their deductible by paying for in-network services, they may still be held financially responsible for an OON bill, as it is charged under an out-of-network deductible.

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*The health care landscape is experiencing a shift in payment models, with insurers tying reimbursement to quality measures and value-based purchasing.*

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## Why It Matters to EM and ME

If an individual is taken to an emergency department at an in-network hospital but receives care from an emergency physician who is contracted with an OON group, the patient may be at risk for a balance bill to account for the difference the insurance will not cover. While a patient may accrue a balance bill by intentionally seeking care OON, balance billing is typically a term used when a patient anticipates their care will be covered by their insurance only to later receive a balance bill from an OON physician or facility. Most prominently, this issue arises when a patient seeks emergency care at an in-network hospital, but the treating physician, who is contracted by a different entity, may not accept the patient's insurance.<sup>1</sup> Approximately two-thirds of hospitals in the United States now outsource to emergency physician staffing companies.<sup>2</sup> As the number of emergency physicians employed by outsourced staffing companies or private physician groups grows, it is increasingly common to experience discrepancies between the specific types of insurance accepted by the physician staffing group and the hospital, thus increasing the prevalence of balance billing. This problem

is also commonly seen amongst other hospital-based medical specialties – radiology, pathology, and anesthesiology – whose services are often outsourced and not directly hired by the affiliated hospital system.

However, as opposed to scheduled care provided by anesthesiologists and radiologists, emergency physicians are required by the Emergency Medical Treatment and Labor Act (EMTALA) to provide emergency care to resuscitate and stabilize any patient who comes to the emergency department regardless of their insurance coverage, in order to be eligible for Medicare reimbursement.<sup>3</sup> This requirement, along with outsourced staffing, leaves emergency departments and physicians with EMTALA obligations particularly susceptible to being caught in the cross hairs of balance billing.

The cost of medical bills can be debilitating for patients. Over a quarter of Americans 18 to 64 years old admit difficulty paying medical bills experienced by either themselves or someone in their household, and this difficulty is ubiquitous regardless of income class or insurance status.<sup>4</sup> The type of insurance a patient carries does not necessarily offer any protection, as the incidence of OON billing in privately insured patients increased from 32.3% in 2010 to 42.8% in 2016.<sup>5</sup> A 2022 report from the Department of Health and Human Services estimated that the average surprise medical bill ranged from \$750 to \$2,600, however extreme cases can place patients in hundreds of thousands of dollars of debt.<sup>6,7</sup>

## How We Got to This Point

In 2010, as the Affordable Care Act was implemented, the Department of Health and Human Services (HHS), Justice Department, and the Department of Labor created federal regulations requiring that a reasonable amount of OON care be paid by insurance companies before the responsibility fell to the patient. Prior to this, there was no requirement for any coverage of OON billing. The method the “greatest of three (GoT)” for OON insurance coverage was created, whereby insurers must pay the hospital or physician the highest amount between:

1. Their usual in-network rate (ie, the insurer’s allowed amount)
2. The usual, customary, or reasonable (UCR) rate (eg, the charge)
3. The Medicare rate

Medical professionals expressed concern at the GoT regulation. The first concern was that in-network physicians often accept lower rates due to certain incentives provided by the insurer, such as increased patient volumes or expedited payment. Accepting these lower rates as an OON provider without the added benefits may lead to financial burden. The second concern was the lack of objective standard for UCR rates, leaving it to be defined by insurance companies. Lastly, Medicare reimbursement rates for hospital services were, at that time, significantly lower than private insurance rates. For physician services

specifically, private insurance paid an average of 143% of Medicare rates.<sup>8</sup> Trends show that reimbursing at Medicare rates does not correlate with inflation. Between 2001 and 2021, reimbursement rates only increased 11%, while the cost of running a medical practice rose 39%.<sup>9</sup> Because of the GoT rule, insurance companies became disincentivized from contracting with emergency groups, putting patients at increased risk for accruing a balance bill.<sup>10</sup>

Since 2010, multiple pieces of legislation have been drafted on how to best reimburse hospitals and physicians for care provided. While the specific mechanisms of how to best reimburse for OON care are up for debate, most proposals have shared the common goal of eliminating patient responsibility for balance bills.

## **Current State of the Issue**

At the end of 2020, Congress passed “The No Surprises Act (NSA),” which took effect Jan. 1, 2022. Patients receiving emergency care, post-stabilization care or other forms of scheduled care, such as radiology and anesthesia services, had been subject to financial burden due to receiving OON care, often without consent. The NSA attempted to free patients from being held accountable from these balance bills. After stabilization, patients should have the option to either transfer care to a facility or provider that is in network with their insurance or remain under their current OON care with responsibility for the balance. The NSA also bans insurance companies from charging OON deductibles without patient consent.<sup>11</sup>

The NSA established an Independent Dispute Resolution (IDR) as the means to a fair reimbursement for medical services without prior contracted agreement between a patient’s insurer and the physician or health care facility. This assumed no preexisting state All-Payer Model or OON billing law. If a state already had existing legislation, the NSA became secondary. Under the NSA, if a physician or group believed they were underpaid by an insurance provider, both groups have 30 days to determine an appropriate reimbursement independently. If they are unable to settle in that time frame, they move to IDR, in which a neutral third party, the independent reviewer, arbitrates the appropriate payment amount. To proceed with IDR, both groups are required to pay a \$200-500 administrative dispute fee. The prevailing side receives the amount they billed for and a refund of their IDR dispute fee.<sup>12</sup>

While the law, as written, was seen as a win for medical professionals, during the final stages of its review, new regulations specified that the independent reviewers settling IDR claims “must begin with the presumption that the Qualified Payment Amount (QPA) is the appropriate OON rate.”<sup>13</sup> The NSA outlined specific criteria detailing the QPA, or how much the insurance companies pay the OON entity. The QPA for a given item or service is generally the median contracted

(“in-network”) rate on Jan. 31, 2019, for the same or similar item or service in a given market area, increased for inflation. As discussed previously in this chapter, the median in-network rate is often significantly lower due to other benefits provided to in-network physicians, and as such QPAs were resultantly lower as well.

These new regulations essentially required the IDR process to consider a median in-network rate as appropriate reimbursement, thus giving insurance companies significant leverage over physicians in the final reimbursement outcomes. Since this final regulatory language was implemented, insurers have begun to cut contracts with physicians who refuse to lower rates. For many insurance companies, it is now favorable to not contract with physicians, given the relative autonomy in price setting afforded to insurers by the regulatory scheme.<sup>14,15</sup>

As renewal contracts are lost or face steep cuts in reimbursement rates, it is theorized that the amount of OON physicians will begin to skyrocket. In an increasingly consolidated insurance market, there may not be other options for physicians to contract with, forcing them to either accept these lower rates or lose their contract, limiting patient’s choices in physicians and potentially delaying care.<sup>16</sup> The financial strain of these changes may also lead to increased physician consolidation. While there may be benefits in negotiation during the IDR process amongst large provider groups and hospitals, multiple studies have demonstrated that this consolidation is a detriment to quality of care.<sup>17</sup> Additionally, consolidation markedly increases health care costs given the lack of competition.<sup>18</sup>

Because of these concerns, in 2021, ACEP, the American College of Radiology, and the American Society of Anesthesiologists filed a lawsuit against the federal government, stating that the regulations established by HHS to include QPA as a starting point for IDR discredit the original congressional intent of the No Surprises Act.<sup>19</sup> As of this writing, this legal battle is ongoing.

As the federal government has sought to create a solution to balance billing, so have states. Since states are mandated to keep balanced budgets, an increase in health care spending, specifically for Medicaid and state employees, may lead to decreased spending for other state needs. Currently, 33 states have some form of policy against balance billing; however, less than half offer comprehensive protection against it.<sup>20</sup>

New York was the first state to enact legislation regarding balance billing, and it utilizes an arbitration process similar to the IDR process of the NSA. This has reduced its OON billing by 88%.<sup>21,22</sup> Connecticut, New York, California, Georgia, New Mexico, and Texas all use FAIR Health data to create a benchmark for OON

reimbursement rates. FAIR Health collects private insurance and Medicare claims from all 50 states and compiles them into a data repository.<sup>23</sup> Maryland utilizes payment formulas and ultimately caps charges at 125% of contracted prices.<sup>24</sup> Other states, such as Arizona and Missouri, have more limited protection against balance billing. For example, in Arizona, the dispute resolution process only applies to claims over \$1000 and must be initiated by the consumer.<sup>25</sup>

While some states have seen success with their own legislation, they are somewhat limited by the Employee Retirement Income Security Act of 1974 (ERISA). With a fully insured employer-sponsored plan, the power is with the insurer to set the benefits while also assuming the financial risk. In a self-funded approach, on the other hand, employers take on this risk, while having the flexibility to choose their benefits. States are able to regulate the former, while ERISA preempts them from regulating the latter.<sup>26</sup> As such, the federal government is responsible for regulating insurance covered under ERISA. Currently, approximately 50% of all job-based coverage is managed through ERISA, as it is self-funded, thus limiting the scope of state legislation alone.<sup>27</sup>

## **Moving Forward**

While physicians, insurance companies, and legislators may disagree on the best way to address the issue of out-of-network surprise billing, ultimately they must agree on a solution that prioritizes patient care without simultaneously increasing health care costs or sacrificing access to care. As the No Surprises Act is implemented in the coming years, it will be critical to monitor its effects on the cost of health care, as many are concerned that the independent dispute resolution process could prove to be unwieldy and expensive, causing insurance premiums to rise and shifting the costs back to the patient.<sup>28</sup> It will also be crucial to observe its effects on emergency departments, as reimbursement rates that are too low could result in the underfunding of our nation's health care safety net. Given the high number of uninsured patients in emergency departments and the unfunded mandate of EMTALA, appropriate reimbursement by private insurers is crucial to the survival of the acute, unscheduled care. While federal solutions are helpful in some instances, it will be critical for states to develop and revise their legislation to address balance billing for insurance plans within their regulatory jurisdiction. Emergency physicians should look into their own state legislatures and model legislation to determine the best solution to balance billing for their own community.

## TAKEAWAYS

- Balance billing occurs when a patient receives care from an out-of-network provider or facility and is held responsible for paying the remaining balance not covered by their insurance reimbursement.
- Because of EMTALA, emergency physicians are required to care for patients regardless of their ability to pay or their insurance coverage, putting emergency departments at high risk for providing care that will not be reimbursed.
- As an increasing number of emergency physicians are not directly employed by hospitals, emergency departments are particularly susceptible to surprise balance billing.
- The No Surprises Act established an Independent Dispute Resolution process to help settle out-of-network billing disputes between health plans and physicians, however the effect of this legislation and its subsequent regulations remain to be seen.
- While more than half of state legislatures have also created policies addressing balance billing, they are preempted by the Employee Retirement Income Security Act of 1974, and as such the federal government is still responsible for roughly half of insurance plans.
- Moving forward, we must continue to advocate for changes that prioritize reducing the cost of health care to patients while ensuring compensation is adequate for the care provided.



# LESS MONEY, MORE PROBLEMS: PHYSICIAN-OWNED PRACTICES

Christopher Clifford, MD; Vishnu Muppala, MD, MPH

**Health care in America has become a booming business.** As such, the practice of medicine is impacted by the same forces at play in the larger market: operating expenses, revenue rates, mergers, industry regulations, politics, inflation, public sentiment, and more.

Yet emergency care is also bound by government mandates, regardless of business concerns. Pricing is often set by lawmakers who can be influenced by third parties with conflicting interests. Insurance companies can retroactively choose not to pay for services provided. Treatment plans ultimately may be subject to oversight by consultants who aren't required to have relevant medical experience.<sup>1</sup> These situations often leave physicians caught in the middle.

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*The safety net is being stretched as patients give up on the byzantine insurance hoops and extended wait times for primary care and specialty appointments, instead either delaying care until chronic problems become acute or simply seeking primary care via the emergency department.*

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## Why It Matters to EM and ME

Medicine – worldwide but especially in North America<sup>2</sup> – is a popular sector for private equity (PE) investors. Mergers and acquisitions have accelerated, with PE driving approximately 70% of the transactions.<sup>2,3</sup>

Emergency medicine is directly affected through investors buying and consolidating EM groups, then changing staffing and payment models. The most concerning, for the specialty and also for patients, is the trend toward hiring non-physician providers with less training, at nominally lower salaries, to maximize profit.<sup>4</sup> A study by the National Bureau of Economic Research, however, shows that emergency care delivered by NPPs may not be cost-effective in the long run, as “NPs significantly increase resource utilization but achieve worse patient outcomes,” including an 11% increase in length of stay and a 20% jump in the risk of readmission.<sup>5</sup>

The specialty is also affected indirectly, as PE investment in family medicine, nursing home care, and other specialties changes the way patients seek care. The safety net is being stretched as patients give up on the byzantine insurance hoops and extended wait times for primary care and specialty appointments, instead either delaying care until chronic problems become acute or simply seeking primary care via the emergency department.

## **How We Got to This Point**

Emergency physician practice groups have been increasing their consolidation for many years. Small practice groups are often challenging to run due to a complex business environment as well as rules and regulations surrounding administration of business and compensation of physicians. For instance, startup costs are a substantial barrier to entry for small group practices. A new practice may accrue costs months prior to developing a reliable income. Large and established groups have the resources to absorb these expenses when entering into a new contract, giving them considerably more leverage in bidding for contracts. Initial expenses include administrative costs, recruitment, billing/coding, malpractice insurance premiums, and compensation. Many of these are fixed costs, which will represent a higher proportion for lower volume versus higher volume contracts.

Physician compensation trends also create a challenging environment for small practice groups. Many models of payment reform have been proposed and implemented including some alternatives to the traditional fee-for-service model which are currently in use. Smaller groups may face more challenges in adapting to these new models, and some of the new models require integration with other specialties in order to utilize them, which thus requires a larger sized, multi-specialty group. However, EM is unique among medical fields. Unlike other fields, emergency physicians manage and treat patients according to presenting symptoms rather than diagnoses. Frequently, there is not a definitive diagnosis made by the time of disposition. As emergency physicians do not provide chronic care, allowing long-term outcomes to be tracked by diagnosis, fee-for-service is a more natural fit for emergency medicine. This makes EM compensation very sensitive to rates set by insurance providers.

In a relative value unit (RVU) based system, EM is particularly sensitive to CMS adjustments of the Medicare "conversion factor" which convert RVUs into dollar amounts. While Medicare compensation rates may go down year-to-year, inflation has been going up, creating a challenging business environment due to decreased financial returns for work done by individual emergency medicine providers in a setting of increased costs. Advocacy on Medicare rate determination can combat this trend. By doing so, the business landscape may allow for easier entry for small, democratic groups and provide a better work environment for providers and better care for our patients.

## Moving Forward

Advocating for appropriate reimbursement from Medicare is crucial for emergency physicians. Medicare rates are set by Congress, with details of the fee schedule and payment program laid out by CMS in regulations. ACEP is constantly following and working on this issue, on a legislative and regulatory level, to ensure that emergency physicians are fairly compensated for their work.

### TAKEAWAYS

- EM practice consolidation is accelerating.
- Consolidation can be problematic in the health care sector.
- Medicare rate determination is a top priority item for EM lobbying and helps to combat consolidation.
- Physician practices have many costs aside from physician salaries, and these practice costs have grown faster than payments, driving increased consolidation in an attempt to control these additional costs.
- Small group practices are challenging to run due to an increasingly complex business environment and a proliferation of rules around the administration of businesses and compensation of physicians (such as tax laws, benefit requirements, quality reporting).
- Federal budgeting, including Medicare rate determination, has a significant impact on physician reimbursement.





# “NEW” METHODS TO CONTROL COSTS: QUALITY AND DATA

*Evelyn Huang, MD; Jacob Altholz, MD; Jesse Schafer, MD*

**Reimbursement structures have become increasingly complex in medicine.** In an effort to contain costs while improving care, the current trend is tying payment to “quality” as defined by CMS, while shifting the measurement and reporting of quality metrics to physicians and institutions. Understanding how these metrics are built, implemented, and managed is vital to understanding the financial incentives that underpin health care.

## Why It Matters to EM and ME

Over the past two decades, CMS has taken a proactive stance to control health care costs by using quality measures as a core component.<sup>1,3</sup> Physicians are meant to report on how often they meet certain predetermined quality measures, and this translates to level of reimbursement.<sup>1,5</sup> But who sets these quality measures and do these quality measures truly reflect high-quality or high-value care?<sup>6</sup> Emergency medicine straddles both the outpatient and inpatient setting so quality measures aimed at addressing health outcomes in those settings do not easily translate to emergency care.<sup>7</sup> Sociodemographic factors outside of the control of emergency physicians influence patient outcomes and can affect how well the emergency physician can meet certain quality measures.<sup>7-11</sup> Additionally, patients often have limited choice in deciding where and how they receive their care in an emergency. We, as physicians, are morally and legally obligated to treat those who seek our care, regardless of a patient’s ability to pay. Our profession’s adherence to this ethical principle historically strains our ability to contain costs, especially since the passage of EMTALA in 1986. EMTALA enshrines in law the requirement that emergency departments provide a medical screening exam (MSE) to anyone and appropriately treat and stabilize any emergency condition.<sup>12</sup> This is often done with limited information, particularly for patients with complex care needs.

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*Emergency physicians can offer insight into metrics that are important to our practice and advocate against metrics that impair, impose unintended consequences, or do not otherwise reflect the standard of care.*

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Within that framework, quality metrics were designed to increase the value of health care per dollar spent. The general idea is to encourage physicians to meet certain “optimal” criteria across different domains related to the processes and outcomes of health care through financial incentives. Physicians aligning with metrics receive higher reimbursement compared to those who score lower on the metrics. However, not all quality metrics achieve this goal, and an intensive focus on metrics may alter an emergency physician’s motivations in other ways, creating unintended consequences in the health care system.

Just over two decades ago, two retrospective studies linked early antibiotic administration with decreased mortality and length of stay in patients with community-acquired pneumonia.<sup>13,14</sup> These studies eventually became the justification behind the creation of a quality metric titled PN-5b. The metric stipulated antibiotic administration within 4 hours of arrival for pneumonia patients. Subsequent research, however, did not reveal any improvement in mortality, need for ICU level care or intubation, or length of stay for those patients receiving early antibiotics compared to those who did not.<sup>15</sup> Moreover, many physicians argued that meeting this metric was not feasible due to inherent systemic limitations with throughput in emergency care.<sup>16</sup> Despite this, definite changes were made in emergency departments across the country with the intent of meeting the metrics and increasing reimbursement.<sup>17</sup> Quality metrics had introduced an external motivation to alter the usual care provided to patients despite poor evidence that it would actually improve care for patients.

The story of PN-5b illustrates the need for rigorous certification of any quality metric, as well as ongoing assessment in light of the latest research findings. If the intent of a specific metric is to improve outcomes and/or save on costs, it must be thoroughly vetted because of its ability to alter clinical practice. Linking quality to financial pressures may also have serious implications for facilities in serving different socioeconomic groups. For example, a county safety net hospital may be expected to have a larger burden of uncompensated care, when compared to a private hospital. Both systems are subject to payment adjustments, whether positive or negative, based on how each hospital meets certain quality metrics and regardless of external forces that influence the quality of care delivered such as boarding, throughput, access to follow up, and community resources. Ideally care would be solely evidence-based, but in a world of limited resources, metrics tied to reimbursement demonstrably change the way physicians practice medicine for better or worse.

## How We Got to This Point

Traditionally, reimbursement has been centered entirely around “fee-for-service” models (ie, payment was based on the actual services a physician delivered). For the patient or the payer, the more services received, the more costs accrued during a visit. The corollary holds true for the physician: the more services provided, the more reimbursement received. The fee-for-service model can incentivize unnecessary testing and procedures, especially for well compensated services. This does not necessarily correlate with “ideal” or “value-based” care. Fee-for-service is felt, therefore, to be a driver of increased health care costs.<sup>18</sup>

While the United States largely remains in a fee-for-service model, changes in the last twenty years have aimed at tying quality of care to payments. Quality measures for Medicare are developed through CMS in cooperation with organizations, such as National Quality Forum (NQF), medical specialty societies, and advocacy groups.<sup>19</sup> These quality measures are then incorporated by CMS into payment programs, in an effort to tie reimbursement to quality. Broadly speaking, quality measures are a series of benchmarks that CMS uses to incentivize quality by requiring individual physicians or physician groups to report their performance on the measures, then adjust reimbursement based on how well certain benchmarks are met. These benchmarks can also be compared among physicians and hospitals, allowing the public to ascertain the “quality” of care assigned by the benchmark. Metrics can vary in the characteristics they might be measuring, some related to the process of care and some to compliance with medical literature (examples in Table 1). Some have even proposed quality metrics related to chief complaints, a proposal that seeks to more accurately match quality measures with the nature of emergency department care, focused on effectively risk-stratifying patients based on their presenting symptoms.<sup>20</sup>

**Table 10.1. Examples of Active Quality Metrics via CMS**

Quality Measure Name	Quality Measure Description
OP-2	“Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival”
OP-22	“Left Without Being Seen” - Percentage of patients who have left without being seen (LWBS) in the Emergency Department
OP-23	“Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 Minutes of ED Arrival”

The passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) solidified the transition toward “value-based programs”.<sup>1,2,21</sup> Presently, CMS uses these benchmarks in the Quality Payment Program, a program designed to reward facilities and organizations that perform better on the benchmarks with higher payments and penalize those that do not meet metrics.<sup>21</sup>

Most emergency physician groups participate in the Merit-based Incentive Payment System (MIPS). Within MIPS, there are multiple “tracks” or “pathways,” customizable to the individual needs and capabilities of a practice.<sup>3</sup> Current reimbursement models depend on a composite performance score from four separate categories:

1. Quality
2. Clinical Practice Improvement Activities
3. Promoting Interoperability
4. Cost

Participating physicians report on relevant data in these categories to calculate a MIPS composite score. The composite score is compared to a pre-assigned threshold then CMS calculates final payment adjustments applied to Medicare Part B claims from that physician. The MIPS Value Pathways (MVPs) are a newer subset of methods to participate in MIPS set to debut in 2023.

## Current State of the Issue

Prior to the passage of MACRA in 2015,<sup>22</sup> CMS used three main pay-for-performance systems to encourage quality in patient care: Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier, and the Electronic Health Record incentive program. These programs were combined to create the Merit-Based Incentive Payment System (MIPS). The purpose of MIPS is to measure performance, with above average physicians receiving a bonus and below average physicians receiving a penalty. As mentioned previously, MIPS has four performance categories: <sup>4,8</sup>

1. Quality
2. Clinical Practice Improvement Activities
3. Promoting Interoperability
4. Cost

The scores in each category are added to determine payment adjustments.

Physicians can participate in MIPS through quality reporting registries. ACEP has developed the Clinical Emergency Data Registry (CEDR).<sup>5</sup> CEDR aims to measure outcomes and patterns in emergency medicine by taking input from emergency physicians and departments across the country. All information is collected from an ED’s electronic medical record and used to both satisfy CMS quality measure reporting requirements and provide helpful feedback to physicians and groups

on practice patterns. CMS has approved CEDR as a Qualified Clinical Data Registry (QCDR) that satisfies MIPS reporting.<sup>6</sup>

CEDR QCDR has several measures that are approved for MIPS, including CT use for minor blunt head trauma, sepsis management, length of stay, avoidance of opiates for low back pain and migraines (ACEP CEDR measures). The goal is to use metrics that were developed within the specialty of emergency medicine and are therefore more applicable to our practice. CEDR also provides feedback to physicians on their performance compared to their peers nationally. This registry allows for individual quality improvement and also national data that can be used to guide policymakers.

CMS uses several criteria when examining new quality measures: importance, feasibility, scientific acceptability, usability and use, and comparison to related or competing measures. Input from a multitude of stakeholders is reviewed as each measure is considered. This can include expert panels, public comments, health care professionals, family members, advocacy groups, health care organizations, other government agencies, and academic researchers. CMS also offers an annual call for submissions where clinicians and organizations representing clinicians can submit new measures.<sup>23</sup>

As MIPS metrics are tied to clinician compensation, there is a concern that they can detract from patient care by focusing physicians on metrics instead of patients. Another issue is whether certain metrics should be used at all. In the ED, patient length of stay increases whenever a hospital is at capacity and patients are boarding. Both of these factors are far outside the control of the individual emergency physician but nevertheless may affect compensation if the “length of stay” quality measure is used.

## **Moving Forward**

The goal of the emergency physician is to provide the best possible patient care. Quality metrics tied to provider compensation should emphasize specialty-driven and evidence-based quality metrics. Emergency physicians can offer insight into metrics that are important to our practice and advocate against metrics that impair, impose unintended consequences, or do not otherwise reflect the standard of care. Quality measures for emergency care should also consider the inherent risk that comes with treating patients for acute, unscheduled care in an environment flush with distractions, impediments, and barriers to the optimal practice of emergency medicine.

## TAKEAWAYS

- Quality measures are now an integral part of reimbursement for emergency care
- Emergency physicians must be involved in determining quality measures that are evidence based, and appropriately risk adjusted for our care setting.
- MIPS measures performance, with above average physicians receiving a bonus and below average physicians receiving a penalty.
- ACEP's Clinical Emergency Data Registry uses metrics developed within the specialty of emergency medicine, and are therefore more applicable to our practice.
- Quality measures impact physician reimbursement, and often have the underlying goal of saving money for payors and increasing risk for the institutions and professionals providing health care.



# MEDICAL MALPRACTICE: THE SWORD OF DAMOCLES

Lindsay Davis, DO, MPH; Ranjit Singh, DO; Ramnik S. Dhaliwal, MD, JD

**Medical malpractice can have devastating effects financially and psychologically on the emergency physician.** Laws vary significantly state by state, but the good news is reform is possible and has been shown to be effective at reducing the burden on physicians.

## Why It Matters to EM and ME

Anyone can sue you for anything, creating cost to you, using up your time and resources, but they still must demonstrate the four key elements to prove that you committed medical malpractice: that you had a duty to treat, that there was a breach of duty, that damages occurred, and that you caused those damages.<sup>1</sup> As an emergency physician you have a 52% chance of being named in a malpractice suit during your career.<sup>2</sup> This high probability should concern all emergency physicians. According to one study, compared to other specialties, emergency physicians are the third most likely to be sued only behind general surgery and obstetrics/gynecology.<sup>2</sup> Jena and colleagues found a different conclusion, showing that emergency physicians have a near average likelihood of being sued, far behind many other specialties and have a lower-than-average payout when sued.<sup>3</sup> Emergency physicians have a median payout under \$100,000 and mean under \$200,000 compared to the mean for all physicians nearing almost \$300,000.<sup>3</sup> The most common malpractice claims for emergency medicine are diagnosis-related, representing 58% of claims, while 25% of claims are procedure-related.<sup>4</sup> Malpractice premiums for emergency physicians vary widely from state to state, from as little as \$8,000/year in South Dakota, Minnesota, and Nebraska to more than \$40,000/year in Delaware and Georgia.<sup>5</sup> These premiums and payouts are a significant burden to the financial health of a practice and are not limited to just direct costs, but further, cause loss of revenue

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*Emergency medicine is a high-risk specialty for medical malpractice, with 1 out of every 14 emergency physicians getting sued each year. Learn how to be an effective advocate in your state, as most malpractice laws are at the state level.*

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from time off and loss of reputation. Lawyers tend to work on a contingency basis, meaning they receive a percentage of settlement if a case results in a payout.<sup>6</sup> Lawyers will charge 33-40% of the awarded amount plus additional fees for costs, leaving patients less than two-thirds of the settlement.<sup>7</sup> The current malpractice system, while stressful for doctors, also may leave patients and families with settlements that do not meet their financial needs.

## How We Got to This Point

In the United States, medical malpractice claims began showing up in the early 1800s,<sup>8</sup> but the legal issue of medical malpractice goes back in history to as early as the Code of Hammurabi in 2300 BC. In this code, there were very severe penalties for malpractice; a surgeon could lose his hands if the patient died. These penalties were awarded after a case was adjudicated before one or a panel of judges, depending on the severity of the accusation. As today, though, the most common of penalties was monetary.<sup>9</sup> Four-thousand years later we saw the explosion of medical malpractice claims in the courts in the 1960s in the United States.<sup>8</sup> The medical malpractice system is a subset of U.S. tort law, which refers to laws involving suffering of harm due to wrongful acts by another.<sup>10</sup> In 2011, the National Conference of State Legislatures (NCSL) recognized a growing problem with medical malpractice and created goals for reforms of the system to limit cost, deter medical errors, and to ensure fair compensation for harmed patients.<sup>11</sup>

There are three types of damages that patients can recover in medical malpractice cases. These fall into the category of economic, non-economic, and punitive damages. Economic damages include the monetary losses the plaintiff has incurred or is likely to incur in the future. This includes costs of medical care and lost wages. Non-economic damages account for an injured person's pain, emotional distress, suffering or other similar issues related to an accident. This can include actual, future, and punitive, but is not supposed to include speculative damages. Punitive damages may be sought if the plaintiff claims the physician practiced with an intent to harm rather than with simple negligence. Caps on non-economic damages (ie, "pain and suffering") place limitations on the monetary compensation a plaintiff can receive following a malpractice claim.

Thirty-three states have enacted caps on damages ranging from \$250,000 to over \$1,000,000 mostly on non-economic awards, while 16 states still do not have monetary caps on medical malpractice.<sup>11</sup> Minnesota and Connecticut do not have specific limits but do have a court review process to limit monetary penalties.<sup>11</sup> The NCSL brief found that low damage caps, restrictive statutes of limitation, and stringent expert witness requirements were associated with the lowest levels of malpractice payments.<sup>12</sup> Medical liability laws have fallen to states, resulting in a wide variety of types of liability reform. In 2013 and 2014,

Dr. Gregory Roslund compiled a 4-part series of articles discussing the current changes to medical malpractice and a detailed discussion of laws and effect on emergency physicians in all 50 states.<sup>5</sup> At the time he showed that states from Florida and Missouri to Massachusetts and Oregon were passing laws that were greatly changing the state of medical malpractice in each state, from overturning caps on non-economic damages (Florida) and ruling damage caps unconstitutional (Missouri) to passing early disclosure, apology and offering laws (Massachusetts and Oregon).<sup>5</sup> Many states with medical malpractice laws that reduce economic damages to physicians and place higher burdens on expert witnesses, such as Texas, Pennsylvania, and Mississippi, have seen dramatic decreases in medical malpractice claims and, in turn, significant decreases in cost and burden on emergency physicians.<sup>5</sup>

## **Current State of the Issue**

Medical malpractice law varies across different jurisdictions from state to state. Despite this fragmentation and wide variability from state to state, several principles must still apply in all cases. This includes the injured patient must show during legal proceedings that there was a duty by the physician, the physician breached that duty, that breach caused injury, and that there were resulting damages.<sup>1</sup> A duty by the physician is established once there is a relationship formed between the physician and the patient in a medical setting. This duty can be formed not only when a physician is caring for their own patient's but also when a physician is covering patients for a colleague or covering a clinic. Breach of duty must be shown by the patient when there is deviation from the standard of care. This is usually defined as care that a similarly situated physician would have provided to the patient had they been the treating physician. In most cases, an expert witness provides information about the standard of care in similar medical settings and explains how there was deviation in the case before the jury, causing subsequent injury. Resulting damages are usually measured in monetary damages, since those are usually more easily calculated and administered. Punitive damages are rare in medical malpractice cases and are usually reserved by courts for more egregious conduct that society has a particular interest in deterring, such as destruction of medical records or sexual misconduct towards a patient.

According to the Medical Malpractice Report by the National Practitioner Data Bank,<sup>14</sup> in 2018, plaintiffs received more than \$4 billion in malpractice lawsuits collectively. The majority of the payouts were from settlements, 96.5%, while 3.5% resulted from court judgments. The good news for physicians is that medical malpractice claims have been on the decline since around 2001 in both number of lawsuits and amount paid out.<sup>15</sup> Across specialties, 7.4% of physicians annually had a claim, whereas 1.6% made an indemnity payment. There was significant variation across specialties in the probability of facing a

claim. Amongst the specialties, emergency medicine ranked lower than surgical specialties and was similar to internal medicine.<sup>3</sup>

Malpractice laws vary significantly from state to state, so the risk that an emergency physician faces will depend on where they practice. Several states such as Texas, California, Nevada, and Indiana have enacted caps on noneconomic damages. These states have shown success at reducing payments to plaintiffs and reducing the cost of malpractice insurance premiums for physicians. The effects of noneconomic damage caps on premiums vary according to the amount of the cap.<sup>16</sup> Compared to no cap, a cap of \$500,000 did not show a statistically significant reduction in malpractice insurance premiums, while a \$250,000 cap successfully reduced malpractice insurance premiums by 20%. Reducing the overall cost of lawsuits has been demonstrated to decrease the costs incurred by physicians practicing defensive medicine, which is about \$50 billion to \$65 billion annually.<sup>17</sup>

Physicians are torn between the competing interests of minimizing health care costs for patients and minimizing their own liability by practicing defensive medicine (eg, ordering potentially unnecessary diagnostic tests). Threatened by the rising price of liability insurance and the negative impact the medical malpractice environment has on access to physicians, many medical societies have advocated for legislative action that would ensure a balanced medical malpractice environment. These advocacy efforts eventually gave rise to “tort reform” in several states, leading to legislative changes to state laws governing medical liability.<sup>18</sup> These reforms on medical liability have been crucial for controlling burdensome rising malpractice premiums and protecting physicians from the burden of frivolous malpractice cases.<sup>19</sup>

## **Moving Forward**

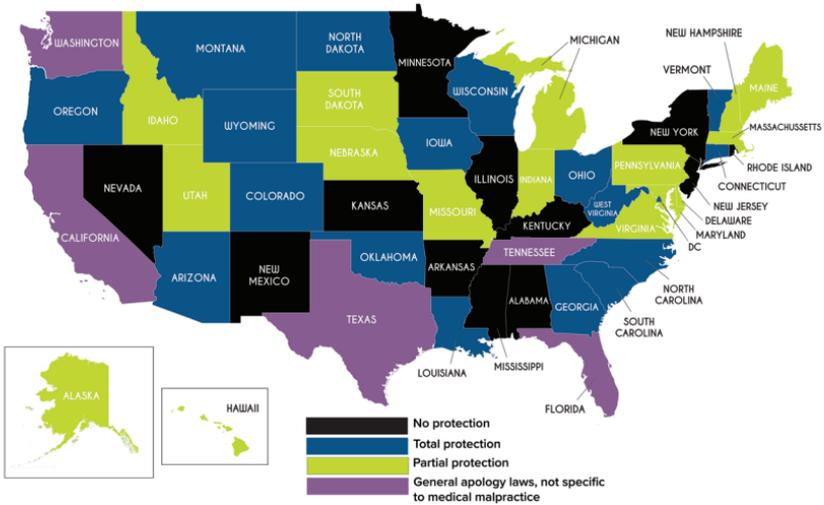
Emergency medicine is a high-risk specialty for medical malpractice, with 1 out of every 14 emergency physicians getting sued each year.<sup>3</sup> As physicians, we are also advocates for our patients. As such, the focus of medical malpractice reform should focus on ensuring patients who are harmed by medical malpractice are made whole, but unnecessary or excessive payouts should be limited. Medical malpractice reforms can decrease financial burden on the health care system, reduce defensive medicine, and also ensure that patients receive fair compensation to meet their needs after a medical error or harm has occurred.

There are many ways to change the overall medical malpractice landscape and create improvements for both emergency physicians and our patients. “Apology laws” are one type of reform, which allow physicians to make apologetic statements to their patients about bad outcomes or medical errors without their statement being admissible in court, should the patient or family later choose to pursue a malpractice claim. The impetus behind the first apology law, enacted

in Massachusetts in 1986, was to encourage open communication and empathy – which can go a long way toward repairing the doctor-patient relationship and staving off litigation. In turn, reducing the number of lawsuits and their payouts can help avoid the increased costs created by the practice of defensive medicine.

Emergency medicine residents should receive education on specific state liability laws, especially pertaining to how we communicate with patients. In “When and Where to Say I’m Sorry,” the Center for Litigation Management offers an overview of how each U.S. state and territory views apologies when speaking with patients.<sup>20</sup> The distinction between empathizing and admitting liability varies greatly by state; 18 states offer total protection, while 12 have no apology laws at all – meaning any statements made to patients can be used in court.<sup>20</sup>

**Figure 11.1. Apology Law Status per State**



In addition to apology laws, there are numerous other ways to achieve medical malpractice reform. Caps on damages, as mentioned above, limit the amount of money that a plaintiff can receive from a malpractice lawsuit, and are currently the most prevalent type of malpractice reform.<sup>21</sup> Limits on attorney’s fees can increase the amount of compensation that a patient receives, rather than their attorney. Both of these interventions can limit the filing of frivolous lawsuits as attorneys will be less likely to pursue cases on a contingency basis if they face limits to the payout that they may receive. An abundance of evidence has shown that tort reforms, such as caps on non-economic damages and reduction of the statute of limitations can reduce the cost of malpractice insurance premiums and increase access to care for patients.<sup>17</sup>

Additional less prevalent but innovative ways of achieving liability reform include:<sup>22</sup>

- Health courts (specialized courts for handling malpractice claims)
- Pre-trial screening panels (early review to determine if a claim has sufficient merit to proceed to trial; also known as an affidavit or certificate of merit)
- Liability safe harbors for the practice of evidence-based medicine (protections for physicians following established guidelines)
- Expert witness qualification requirements
- Early disclosure and compensation programs

ACEP has a long history of supporting tort reform. ACEP policy supports a broad variety of tort reforms, including caps on non-economic damages, controls on attorney's fees, immunity for following guidelines, apology laws, and expert witness requirements. To specifically address liability in emergency situations, ACEP has supported legislation which would offer emergency and on-call physicians who provide EMTALA-related services with temporary protections under the Federal Tort Claims Act.<sup>23</sup>

## TAKEAWAYS

- Most emergency physicians will face a medical malpractice lawsuit at some point in their career.
- Be familiar with the malpractice laws in the state in which you practice, and in any state you are considering for future practice.
- Learn how to be an effective advocate in your state, as most malpractice laws are at the state level.
- Advocate for reforms that will help emergency physicians while understanding how the changes improve care for patients by increasing access to care and decreasing health care costs.



# SCOPE TRIALS AND TRIBULATIONS

Miltiadis Kerdemelidis, MD; Stefania Markou, DO, MPH; Andrew Little, DO

**As the field of emergency medicine continues to grow and expand, so does the role that non-physician providers (NPPs) wish to take in the specialty.** Understanding how we got to where we are plays a vital role in knowing where to go from here.

## Why It Matters to EM and ME

As they require less time to train and are cheaper to employ, employers have moved to the use of NPPs, and this move is leading to less safe care for patients and fewer jobs for board certified/board eligible emergency physicians.<sup>1,2</sup> Of all the threats to EM, scope creep and increasing number of NPPs is one that all EM doctors should be worried about.

## How We Got to This Point

The United States continues to face an imbalance in supply and demand for physicians. Filling this void, the number of non-physician providers (NPP) entering the health workforce and the ED specifically has increased substantially in the past few decades.<sup>3</sup> Nationwide, there were an estimated 355,000 licensed nurse practitioners (NPs) as of 2022, representing a 9% increase in a single year.<sup>4,5</sup> Physician assistants (PAs), meanwhile, voted in 2021 to change their name to “physician associates”<sup>6</sup> as they welcomed a record number of newly certified PAs to their ranks, surging to a 2021 total of 158,470 certified PAs in the U.S. – a 5-year increase of nearly 30%.<sup>7</sup> In this same time frame, as NPP numbers have risen, attrition of emergency physicians picked up speed, outpacing forecasts and topping a 5% attrition rate, even as fewer medical students expressed an interest in the specialty.<sup>8,9</sup>

The level of practice autonomy granted to NPPs is dictated by state law and hospital bylaws, and although NPs and PAs typically have similar levels of autonomy in EDs, they take different training routes, as seen in Table 12.1.<sup>10</sup>

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*Patients deserve to know exactly who is providing their care, and that the highest quality care in the emergency department is overseen by an ABEM-certified physician.*

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**Table 12.1. Comparative Training Characteristics of NP, PA, and Physician Degrees<sup>10</sup>**

	NP	PA	Physician
<b>Clinical contact hours</b>	500	2,000	5,000+*
<b>Degree granted</b>	Master's	Master's	Doctorate
<b>Post-graduate training</b>	Not required	Not required	Required; 3- or 4-year residency; 13,500–18,000* clinical hours
<b>Emergency certification</b>	ENP-C available but not required	Emergency CAQ available but not required	ABEM board certification

*\*Assumes 60-hour work week*

The PA Education Association (PAEA) reported 351 PA programs in the 2022-2023 application cycle,<sup>12</sup> and of those, 300 are accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA).<sup>13</sup> The Society for EM PAs (SEMPA) has created postgraduate training standards as a framework that new and existing EM PA postgraduate programs can use to improve or create EM PA postgraduate programs.<sup>10</sup>

PA postgraduate programs range in length from 1-2 years, with most lasting 18 months. Many PA postgraduate programs are housed in institutions with EM residencies. Many of those integrate their didactic curricula, so PAs join EM resident educational conferences, journal clubs, clinical rotations, simulation, and research requirements.<sup>15</sup> When a limited number of procedures are available in a given training environment, increasing the number of trainees by including NPPs may decrease the procedures available for EM residents to perform as part of their training. In 2022, 277 EM residency programs recruited nearly 3,000 newly minted emergency medicine residency-trained physicians a year; the number of postgraduate training programs available to NPs and PAs is much smaller.<sup>9</sup> However, with NPP specialty organizations attempting to standardize training, there continues to be overall growth in the numbers of NP and PA postgraduate programs and a push toward completing advanced training after graduating from NP/PA school.

The proportion of ED patients seen by an NPP has substantially increased over time. According to the National Hospital Ambulatory Medical Care Survey, NPPs saw nearly 25% of all ED patients in 2020 (10.1% seen by NPs, 13.4% seen by PAs)<sup>16</sup> – up from just over 20% of ED patients seen by NPPs in 2015<sup>17</sup> and only 5.5% in 1997.

NPPs see a range of acuity levels but often staff high-volume, fast-track, or express care sections within EDs. Compared to physicians, NPPs often see lower acuity patients, with only 11% of patients seen by NPPs in the highest triage category.<sup>18,19</sup>

In addition to caring for a large and varied level of ED patients, NPPs have been working in more EDs and working more hours. According to surveys from the Emergency Department Benchmarking Alliance, the percent of EDs utilizing NPPs ballooned from 23% in 2010 to 62% in 2016. Moreover, NPPs are working more of the total hours available. In 2010, NPPs worked 53% of physician staffing hours; by 2016, this number had risen to 64%.<sup>11</sup> According to the National Center for Health Workforce Analysis, “between 2010 and 2025, the supply of non-primary care [NPP] FTEs is expected to grow by 141% overall, with growth anticipated in every field where these providers are represented.”<sup>20</sup>

EM physicians perceive a difference between NPs and PAs: a poll revealed that EM physicians believe NPs tend to use more resources as compared to PAs, and that NPPs use more resources than physicians when seeing patients with similar emergency severity index levels.<sup>21</sup> In addition, there was more interest in hiring younger, less-trained PAs as compared to NPs, with a possible reason cited as the clinical education for PAs was thought to be stronger than NPs.<sup>21</sup> Although the data is obscured by different state laws regarding NPPs, it may partly explain differences in levels of physician oversight for NPPs. In fact, from the NHAMCS respondents, only half of the patients who received care from a PA during an encounter also saw a physician, as compared to two-thirds of those who received care from a NP.<sup>16</sup>

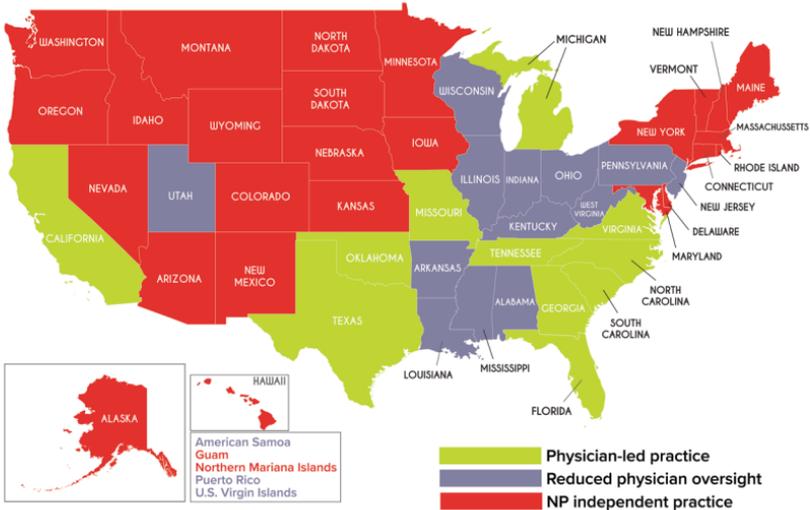
## Current State of the Issue

As the use of NPPs balloons in EDs, NPPs seek to increase their scope of practice – and it’s working.<sup>22</sup> Notably, New York, Massachusetts, Delaware, and Kansas all granted NPs full practice authority within the past 5 years (see Figure).

“**Scope of practice**” is the term describing the regulatory means of guiding the activities different medical professionals are able to perform and the independence afforded to their practice. State legislatures govern this, and they are influenced by Congress, CMS, and the Federal Trade Commission.

With differing scope of practice laws in each state, health professionals are subjected to various rules. Some NPPs practice alongside a physician, while others practice independently. Some states have enacted legislation allowing for NPs to practice with full autonomy. The degree of independence of NPP practice thus varies significantly from state-to-state and from ED-to-ED.

**Figure 12.1. Nurse Practitioner Practice Authority, February 2023<sup>22</sup>**



Oversight of PAs may mandate a physician be physically present onsite, or available through phone/videoconferencing, or simply review/sign PA medical documentation. Even further complicating this, some states allow PA oversight to be dictated at the institutional level. These laws affect NPP and physician liability as well as overall medical workforce coverage. For example, states with fewer NPP restrictions tend to have higher numbers of NPPs practicing in comparison to physicians.

NPP advocacy groups have lobbied to expand NPP coverage in the ED, focusing on increased independence from physicians. Some NPP groups have an explicitly stated goal of full practice autonomy. With continued physician shortages, gaps in coverage exist and NPPs position themselves as a means to fill the gap and curb health care spending. This has led to increased autonomy in states with the largest gaps in coverage.

In response, the AMA has created the Scope of Practice Partnership (SOPP).<sup>23</sup> The SOPP, with EM representation provided by ACEP, tackles scope creep via public and legislative advocacy.

### Truth in Advertising

As NPP scope expands, so do concerns of misrepresentation of credentials. Patients are confused by the expanding ability of NPPs to prescribe treatments and perform procedures, and some NPPs use the title of “doctor” to represent doctorates other than MD and DO. In efforts to increase transparency, the AMA

launched the Truth in Advertising campaign.<sup>24</sup> In building this initiative, the AMA queried patients to determine their understanding of the distinction between medical doctors and other doctorates. They discovered 45% of patients do not find it easy to tell licensed medical doctors apart from others identifying themselves as “doctors” in the health care setting; 39% believe a doctor of nursing practice is a medical doctor.<sup>24</sup>

The model legislation developed by this campaign:

- Requires all health care professionals to clearly and accurately identify themselves in all publications, advertisements, and other communications.
- Requires all health care professionals to wear, during patient encounters, a name tag that clearly identifies the type of license they hold.
- Prohibits advertisements or websites advertising health care services from including deceptive or misleading information.

One of the most frequently repeated claims in seeking greater autonomy for NPPs is that this autonomy will improve access to care for patients. However, studies and anecdotal reports are largely not supporting those claims, as NPP training and jobs continue to grow in areas with strong access to health care, while still leaving large swaths of less-populated regions scrambling for care.<sup>25</sup> While advocates of NPP autonomy may argue that use of NPPs can lead to cost savings, data demonstrates that NPPs tend to order more tests in comparison to physicians,<sup>26</sup> which increases total costs of care.

## Moving Forward

According to the ACEP Code of Ethics for Emergency Physicians, emergency physicians have an ethical duty to promote population health through advocacy and to participate in “efforts to educate others about the potential of well-designed laws, programs, and policies to improve the overall health and safety of the public.”<sup>27</sup> Physician advocacy can range from working toward state health care reform to advising a local school board. Advocacy activities might include attending a physicians’ day at the state capitol, testifying before a committee, or corresponding and meeting one-on-one with an elected official.

In the setting of scope creep, however, all emergency physicians must be mindful of the line between advocating for your patients and your specialty and denigrating other members of the health care team. The message is not that NPPs are “bad” and physicians are “good;” it is that patients deserve to know exactly who is providing their care, and that the highest quality care in the emergency department is overseen by an ABEM-certified physician.

## TAKEAWAYS

- As the increase in NPPs continues among emergency medicine, every EM physician must know the laws governing the scope of practice of NPPs in their state.
- EM physicians need to advocate for the continued importance of physicians as health care team leaders in emergency medicine.
- PAs and NPs have substantially fewer hours of training and less standardized training (particularly in the case of NPs) than physicians.
- The drive to decrease health care costs by payers and increase compensation for leaders of provider groups has led to the increasing use of NPs and PAs rather than emergency physicians in the provision of emergency care.
- Scope of practice is a dynamic issue that requires ongoing advocacy at the state level, in collaboration with other specialties, and recognizing the differences between types of nonphysicians.
- EM physicians need to prioritize working with government representatives and NPP organizations to promote a culture of transparency in providing patients accurate information about provider's credentials and roles.



# BOARD CERTIFICATION: WHY IT MATTERS

*Krishna J. Patel, DO; Sandra Gad, MSc; Kathleen Cowling, MS, DO, MBA, FACEP*

**In our humble beginnings, emergency medicine was the melting pot of various specialties, making us now one of the most flexible and adaptive areas of medicine.** However, this has also contributed to dissonance with regards to board certifying organizations- American Board of Emergency Medicine (ABEM), American Osteopathic Board of Emergency Medicine (AOBEM) and Board of Certification in Emergency Medicine (BCEM). ABEM and AOBEM certify emergency medicine residency trained physicians only, while BCEM will certify non-emergency medicine specialty trained physicians. And in many areas, emergency departments are still staffed by physicians with no EM certification at all.

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*To the layperson and general public, stating that one is a board-certified physician in a certain field implies that a physician is an expert in that field. True expertise in medical specialties can only be reached by completing specialized residency training.*

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## Why It Matters to EM and ME

The practice of emergency medicine requires physicians to have a broad fund of knowledge and thorough specialized training. Our patients come to us in their most vulnerable states, and they deserve quality care from well-trained physicians. This can only be effectively achieved with formalized emergency medicine graduate medical education. The persistent push for non-emergency medicine trained physicians to obtain board certification through BCEM questions the legitimacy and value of an emergency medicine residency.<sup>1</sup> Training in a primary care residency program focused on family medicine, internal medicine, pediatrics, or general surgery is not the equivalent to the number of hours of training in acute care required during an emergency medicine residency. The same would be true for emergency physicians wanting to practice a specialty in which they are not residency-trained.

Emergency medicine residents are required to meet rigorous detailed milestones during training and must demonstrate competency in a multitude of procedures set forth by the American Council of Graduate Medical Education (ACGME).<sup>2</sup> These benchmarks ensure that every resident graduating from an accredited emergency medicine residency program is a highly proficient and qualified physician. The ACGME requirements differ from specialty to specialty,<sup>3</sup> therefore it is unreasonable to assume that non-EM trained physicians would have achieved competency in emergency medicine. The specialty of emergency medicine “has grown such that residency training is widely available and should be the pathway for new physicians entering the practice.”<sup>1</sup>

## **How We Got to This Point**

Once known as the “weakest link of the hospital,” emergency departments have evolved into the strongest frontline defense of any hospital system.<sup>4</sup> Our specialty was created to fill the vast gap in health care that once existed in an acute setting. A growing number of physicians in the early 1960s began training in emergency medicine. This paved the path for ACEP to be established in 1968.<sup>5,6</sup> The college initially was composed of physicians from various other specialties who took a keen interest in developing emergency and trauma medicine. As the specialty gained national momentum, a physician trained as a hematologist in Cincinnati sought to improve emergency care through formalized education. The first emergency medicine residency program was born in 1970 at the University of Cincinnati.<sup>6</sup> Through continuous national expansion and advocacy, emergency medicine became recognized by the American Board of Medical Specialties in 1979. Thereafter, specialized boards for emergency medicine were created and the American Board of Emergency Medicine (ABEM) certified its first physicians in 1980, later gaining conversion to primary board status in 1989.<sup>6</sup> During this conversion period, the Accreditation Council for Graduate Medical Education (ACGME) approved specific requirements for emergency medicine residency training programs.

Prior to establishing primary board status, physicians from other specialties not undergoing emergency medicine residency training could still be certified under ABEM with proof of work experience in emergency departments. After a lengthy grace period, ABEM eliminated the “practice track” option of being board eligible into the specialty in 1988.<sup>7</sup> Yet some physicians still wanted to practice emergency medicine without formalized training, and in 1987, they created the Board of Certification in Emergency Medicine. Later that year, BCEM certified its first physicians who were not ABEM or AOBEM eligible. In the years to follow, there was rising strife among residency-trained emergency medicine physicians versus non-EM trained physicians. This contributed to the formation of another body of emergency physicians: the American Academy of Emergency Medicine (AAEM). However, currently both bodies of physicians, ACEP and AAEM, only

recognize ABEM or AOBEM certified emergency physicians as qualified trained specialists in the field.<sup>4,7</sup>

In contrast, BCEM is a certifying board that provides eligibility for non-EM trained physicians to be certified in emergency medicine. BCEM is a member of the American Board of Physician Specialties (ABPS)<sup>8</sup> – not to be confused with the American Board of Medical Specialties. To be certified in emergency medicine, BCEM offers three pathways. One of the aforementioned pathways requires completing an approved residency in a primary care specialty (family practice, internal medicine, pediatrics, or surgery). Candidates must also demonstrate at least 5 years of full-time emergency medicine experience with a minimum of 7,000 hours in the practice of emergency medicine, where a minimum of 1,400 hours per 12-month period is accumulated, although there is a slight difference in timeline depending on the residing state.<sup>9</sup> Another alternative pathway requires candidates to complete either a 12- or 24-month emergency medicine fellowship approved by the BCEM. There are currently 13 approved BCEM fellowships available.<sup>10</sup> All candidates regardless of BCEM eligibility track, must pass both an initial written exam with a subsequent oral examination to be fully recognized. Additionally, all candidates must provide 10 case reports in which they led emergency medicine care.<sup>9,11</sup>

It is important to note that the ACGME is the overarching governing body for all graduate medical residency programs, while there is no umbrella organization that sets education standards for BCEM-recognized emergency medicine fellowships – although the ABPS-affiliated American Association of Physician Specialists, Inc. (AAPS), does offer an EM fellowship recognition program.<sup>12</sup> This is an important distinction, as the ACGME has rigorous and detailed requirements for emergency medicine residents to complete in order to demonstrate specialty competency.<sup>2</sup>

## Current State of the Issue

After closing the pathway for non-emergency medicine specialty trained physician certification by ABEM, a growing number of physicians pushed to be grandfathered into the specialty. This led to the landmark case of *Daniel vs. ABEM*. In 1990, Gregory Daniel and numerous co-plaintiffs sued ABEM in an effort to reopen this certification tract. After 15 years of court arguments, the case was ultimately dismissed in 2005, reaffirming the current residency-based approach for physicians wanting to specialize in emergency medicine.<sup>13</sup>

However, this case did not put an end to all certification pathways for non-emergency medicine trained physicians. AAPS, alongside its affiliate, ABPS, continues to advocate for alternate certification pathways without requiring emergency medicine residency training. ABPS was created as the parent organization to BCEM, and BCEM accounts for approximately 70% of ABPS board

certifications. The exact number of physicians certified through ABPS, and BCEM specifically is not available and is proprietary information, per ABPS leaders.<sup>1</sup>

Recognition of a “board certified” physician is ultimately up to the licensing state medical board. However, this varies from state to state. ACEP, AAEM, and EMRA, among other widely known and respected emergency medicine associations, stand by the American Board of Medical Specialties (ABMS) and Boards of Certification of the American Osteopathic Association in defining a “board certified” emergency medicine physician as one who has passed qualifications through ABEM/AOBEM. BCEM certified physicians are recognized as emergency medicine “board certified” physicians in multiple states, including Texas and Florida.<sup>14</sup> In Oklahoma, BCEM and ABPS were briefly successful in gaining “board certified” recognition in 2010, before this decision was swiftly reversed after “pressure from emergency physicians and state legislature.”<sup>14</sup> To date, ABPS/BCEM and ABMS/ABEM continue to be on colliding paths in numerous states. ACEP continues to recognize “only ABEM and AOBEM as the only certifying bodies for emergency medicine.”<sup>1</sup>

**So why does using the term “board certified” matter?** To the layperson and general public, stating that one is a board-certified physician in said field implies that a physician is an expert in that field. True expertise in medical specialties can only be reached by completing specialized residency training.<sup>14</sup> The premise of BCEM certifying non-emergency medicine specialty trained physicians in emergency medicine questions the legitimacy of residency based medical education in general.<sup>14</sup> Additionally, a physician who practices outside of their scope of specialty and residency training may be a patient safety risk.<sup>14</sup> If physicians fail to earn certification by the end of their eligibility period, they are no longer considered board eligible and must complete one year of residency retraining or a fellowship program in order to reestablish eligibility. But BCEM offers board certification options to these physicians “who are no longer board eligible.”<sup>15</sup> This is alarming and threatens the safety of patients.

BCEM continues to claim the nation has an “ongoing shortage of rural physicians in emergency medicine” and this is why “certification options offered by ABPS are critically important.”<sup>16</sup> But it is worth noting that the Emergency Medicine Physician Workforce Projections for 2030 predict a surplus of 7,845 emergency physicians in 2030, with the majority of these physicians being emergency medicine residency trained.<sup>17</sup>

## Moving Forward

Patient care extends beyond a brief consultation with an individual patient. The scope of physicians' duty to patients includes public health, political advocacy, cultural acceptance, and societal awareness. The future of emergency medicine depends on today's advocacy efforts. We must continue to show representation to our respective state legislators and state medical boards.

"EMRA believes that the only pathway to the independent practice of emergency medicine in the 21st century is completion of an ACGME/AOA accredited emergency medicine residency training program and board certification by ABEM or AOBEM."<sup>18</sup> It is our responsibility to educate hospital systems the value an ABEM/AOBEM board certified emergency medicine physician brings to humanity.

### TAKEAWAYS

- American Board of Emergency Medicine (ABEM)/American Osteopathic Board of Emergency Medicine (AOBEM) offer board certification to emergency medicine residency trained physicians only.
- Board of Certification in Emergency Medicine (BCEM) certifies non-emergency medicine specialty trained physicians.
- The leading nationally recognized and respected emergency medicine organizations - AAEM, ACEP, and EMRA, all recognize only ABEM and AOBEM as acceptable certifying bodies for emergency medicine.
- It is our responsibility to educate hospital systems and the public about the value an ABEM/AOBEM board certified emergency medicine physician brings to society.
- The future of emergency medicine depends on today's advocacy efforts. We must continue to show representation at our respective state legislators and state medical boards.
- Physicians from non-emergency-medicine residencies continue to practice and train in emergency medicine, and have sometimes sought alternate board certification to do so (ABPS), so ongoing advocacy for the ACEP definition of an emergency physician is critical.





# CORPORATE PRACTICE OF MEDICINE

## CORPORATIONS ARE PEOPLE TOO?

Nicholas S. Imperato; Aaron R. Kuzel, DO, MBA; Angela G. Cai, MD, MBA

**Laws regarding the Corporate Practice of Medicine describe a doctrine that places limitations on the practice of medicine to licensed physicians.** Such laws prohibit corporations from practicing medicine, directly employing a physician, or influencing the medical decision-making of a physician in their practice. The majority of states within the United States have laws prohibiting the corporate practice of medicine, but limitations as to the practice vary state to state. These prohibitions seek to protect and preserve the practice of medicine as well as discourage the profit-generating mentality of corporate business practices or the “commercialization” of care.<sup>1</sup>

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*The concern with corporate actors in medicine is the conflict of interest between financial performance vs. the patient care, educational, and research missions of EM practice and training.*

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Within the specialty of emergency medicine, the Corporate Practice of Medicine has been an issue of debate, as a rising number of corporate-backed medical groups employ emergency physicians across the specialty. At the time of publication, the American Academy of Emergency Medicine Physician Group (AAEM-PG) has filed a lawsuit against Envision Healthcare with accusations of illegal corporate practices of medicine in the Superior Court of California.<sup>2</sup> The lawsuit has been supported by an amicus brief by ACEP and a declaration of support by EMRA. The topic is complex and affects much of the life and practice of emergency physicians – and it continues to be an area of debate within the specialty. With such practices, there are certain concerns such as a corporation’s political and business alignment. Will the corporation first prioritize their alignment with their shareholders or to their patient? Will physicians continue to have autonomy over their medical decision-making, or will this decision-making be altered to maximize profits?

## The Corporate Practice of Medicine Laws

The corporate practice of medicine (CPOM) is a legal doctrine that prohibits companies from practicing medicine or directly employing a physician to provide medical services.<sup>3</sup> These laws uphold ethical standards that separate medical judgment from the influence of profit incentives by corporate or private entities. Most states have laws prohibiting the corporate practice of medicine, however, almost every state provides broad exceptions to the doctrine. All states with laws on the corporate practice of medicine allow for professional corporations or associations to provide medical services if wholly owned by physicians.<sup>3</sup> Additionally, hospitals and hospital systems also receive exemptions to employ physicians to provide medical services, although there are also laws prohibiting the hospital employer from interfering with the physician's independent medical judgment.<sup>4,5</sup> Texas state law has strict protections for independent physician medical judgment so that a physician cannot be disciplined for reasonably advocating for patient care.<sup>6</sup>

Since these laws have been enacted, they have been regularly shaped by legislation, federal and state regulation, as well as decisions from higher courts and state's attorney generals. Many of the specific regulations vary between the states, but in general, the states mandate that all or the majority of shareholders of a medical corporation must be physicians licensed within the state of the medical practice.<sup>3</sup> Each state allows for the formation of professional corporations with the specific purpose of these corporations to provide a professional service. How these corporations operate and render their services varies from state to state. In Arkansas, for example, the board of directors and shareholders of a physician group must be physicians licensed in Arkansas.<sup>7</sup> In contrast, the Colorado statutes allow for a physician assistant to be a shareholder of a corporation, provided physician shareholders maintain majority ownership in the corporation.<sup>8</sup> Corporate practice of medicine laws are often shaped not only by legislative and regulatory bodies but also by boards of medical licensure. Often boards of medical licensure will offer exceptions to the doctrine as it pertains to the employment of physicians, as long as the physician maintains autonomy in decision-making.

## Why It Matters to EM and ME

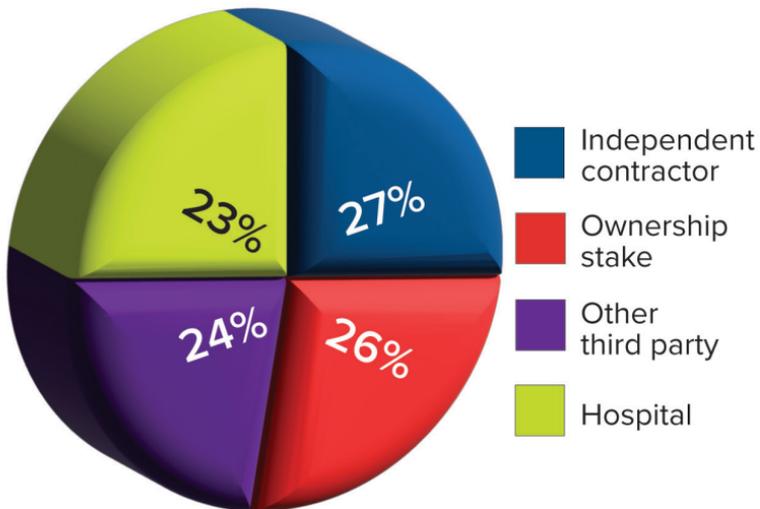
Understanding the corporate practice of medicine doctrine is critical for emergency physicians as this intersects with the employment and practice of the emergency physician. Physicians in all specialties are now more likely to be employees rather than owners of their own practices. Prior to 2018, the majority of physicians owned their own practice, but now 45.9% of physicians have ownership stakes in their practices, whereas 47.4% are employed. Emergency medicine has the lowest proportion of physicians who have an ownership stake in their practice (26.2%). Further, emergency medicine has the highest

percentage of physicians who work as independent contractors (27.3%) and the highest proportion of physicians directly employed with a hospital (23.3%).<sup>9</sup>

One of the greatest concerns from emergency physicians as it relates to the corporatization of medicine is the loss of physician autonomy and the conflict of interest that sometimes exists between profit generation and patient care best practices. During a 2022 Federal Trade Commission Listening Session with ACEP President Dr. Gillian Schmitz, she shared the results of a questionnaire to ACEP members that found that greater than half of those emergency physicians affected by corporate mergers of acquisition experienced a negative impact to their medical decision-making autonomy. This interference can significantly impact quality of care and patient safety.<sup>10,11</sup> Leaders within emergency medicine raise concerns that as corporations seek to maximize profits, there will be drastic reductions in physician autonomy, quality care, and patient safety.<sup>12</sup>

The staffing structure of emergency physicians through physician practice management groups with corporate structures (discussed below) has led to concerns about lack of due process protections.<sup>10</sup> The right to due process is well-established in health care through the Healthcare Quality Improvement Act of 1986 and affirmed by the Joint Commission via the Comprehensive Accreditation Manual for Hospitals, and the 14th Amendment of the U.S. Constitution.<sup>13</sup> Emergency physicians, who are frequently employed through staffing groups, often do not have access to due process protections guaranteed to physicians directly employed by the hospital; many are asked to waive due process rights as a condition of their employment contract.<sup>14</sup>

**FIGURE 14.1. Emergency Physician Employment Landscape**



## How We Got to This Point

CPOM has shaped the United States health care system and will continue to mold it for years to come. In the late 19th-century, mining, lumber, and railway corporations began to expand significantly, leading many of them to employ physicians to provide care directly to their employees. While these companies employed physicians to provide medical services, other companies decided to contract with physicians in exchange for a portion of all medical fees that were charged. These companies would also help market the physician's services to the public. As these companies' interest in physician services grew, decision-making began to move out of the physicians' hands and into those of laypeople.<sup>15</sup>

The CPOM doctrine arose in the early 1900s, essentially as a way to prevent corporations from practicing medicine or employing physicians, with an overarching goal of "preserving the sanctity of an independent physician-patient relationship."<sup>16</sup> This general principle prohibits the practice of medicine by an unlicensed individual and prevents corporations from practicing medicine. There was fear that it was unlikely that the motives or interests of physicians would align with the potential profit-centered mentality of corporations. This doctrine was built on the premise of three main policy concerns:<sup>3</sup>

- Corporations either employing physicians or practicing medicine would lead to the overarching corporatization of medicine.
- If physicians were employed by corporations, then they may be unable to provide unbiased, independent medical decisions.
- There may be a distinct opposition between shareholder's desires and physician's or patient's interests.

Despite those policy concerns, the health care system continued to evolve and consolidate, and the Mayo Clinic became a model for bringing specialists together into larger group practices. These large groups of physicians began the model of prepaid group plans. Eventually, these prepaid group plans began to enroll employee groups, offering capitation fee-treatment arrangements. One of the first plans was the Group Health Association of Washington, with later similar groups such as the HIP Health Plan of New York or Kaiser-Permanente. These consolidated practices and the employment of physicians by corporations laid the groundwork for the further corporatization of emergency medicine.<sup>15</sup>

The corporatization of emergency medicine and the health care system, in general, is directly related to the rise of managed care organizations (MCOs). In 1973, under the Nixon Administration, the Health Maintenance Organization Act (HMO) was passed. Through this piece of legislation, federal funds were made available to help develop HMOs throughout the nation. Similar to the prepaid groups discussed previously, the belief behind HMOs was that capitated, prepaid medical care would provide an effective and less expensive alternative to the

fee-for-service model. MCOs are large organizations, often indistinguishable from corporations or health insurance organizations, that integrate financing, insuring, and delivering care while controlling the utilization of services. In an effort to reduce costs, we have moved towards a significantly more corporatized system.<sup>15</sup>

Physician groups have also corporatized by forming physician practice management (PPMs) or contract management groups. These groups initially started as physician-owned staffing agencies that helped ensure that well-trained physicians consistently staffed emergency departments. In early 1961, Dr. James Mills Jr., a physician in Virginia, became one of the first to develop and utilize the present-day ED structure. Emergency patients at his Alexandria Hospital were charged \$5 per visit, and the ED was covered by physicians working various shifts throughout the day. Around the country, hospitals dealt with the increased patient volume by contracting full-time physicians to staff their EDs. To increase efficiency in staffing, PPMs were then developed. As many of these groups began to expand and emergency medicine became a profitable business, outside investors such as private equity and public stock shareholders have become investors or owners in these businesses.<sup>17</sup>

PPM structures raise questions about appropriate levels of overhead. All physician practices have backend expenses or overhead that must be accounted for in the practice and these expenses offset the revenue an individual physician receives. These expenses can include malpractice insurance premiums, coding and billing costs (including compliance, audit appeals and collections), physician management services including medical director salaries, physician recruiting and onboarding costs, personnel and payroll expenses, and other group administrative expenses.<sup>18</sup> How these expenses are paid varies with each group and can range from direct billing of expenses to a management services company or backend percentage-based fee. The concern with these overhead fees in any practice not controlled exclusively by physicians, including PPMs, is that the administrative arm can increase the fee beyond the actual expenses of the group to generate profit. Where the administrative arm has the power to set fees and collect them without regard to the expense, there is the potential for abuse and ethical concerns.

## **Current State of the Issue**

### **Emergency Medicine Practice Models**

The nature of emergency medicine does not lend itself to solo physician practices. Emergency physicians can be employed by hospitals, academic institutions, physician practice management groups (which may be physician-owned or corporate-owned), federal entities (such as the U.S. Armed Forces,

Veterans Affairs, Indian Health Services, or the CDC) or as independent contractors.

## **Hospitals and Academic Practices**

Emergency physicians can be directly employed by a hospital or academic medical center. Employees of hospitals and academic groups often enjoy guaranteed salaries and benefits and avoid the administrative burdens of running a private practice. Nonprofit hospitals and health systems are classified by the Internal Revenue Service as charities and, as such, are not obligated to pay federal income or state and local property taxes. For-profit hospitals are owned either by investors or shareholders of a publicly traded company.<sup>19</sup>

For-profit hospitals can have a wide range of owners, including physicians, individual investors, publicly traded groups, private equity firms, or some combination of these owners. Per the 2021 MedPAC report “Private Equity in Medicare”, in 2020, 4% of hospitals, or 115 hospitals, were owned by private equity firms, and 22% of hospitals were owned by other for-profit entities such as publicly traded corporations and physician practices, while the remaining 74% of hospitals were nonprofit or government-owned facilities.<sup>20</sup> One of the largest examples of private ownership of a health care system is the Hospital Corporation of America (HCA Healthcare), which owns 184 hospitals. HCA Healthcare represents 20% of all for-profit hospitals and has shifted ownership numerous times between private and public ownership, including a period of private equity ownership.<sup>20</sup>

One particularly controversial private equity acquisition occurred in 2018 with the purchase of Hahnemann University Hospital in Philadelphia by a private equity firm, followed by the firm quickly closing the hospital a year later – effectively removing a safety net from a vulnerable population center<sup>21</sup> and disrupting the education of hundreds of residents.<sup>22</sup> However, given the dire financial situation of the hospital, it is unclear whether the hospital would have remained open if publicly traded or physician-owned.<sup>20</sup>

## **Physician Group Practices**

Emergency physicians can join a spectrum of group practices, or PPMs, which maintain staffing contracts with emergency departments and hospitals. PPMs range in size from a small group of physicians covering one emergency department to group practices that cover multiple hospitals within a region or nationally.

## Differentiating Features

There are many features that differentiate various EM group practices, including democratic governance, billing and financial transparency, independent contractor status, and ownership (physician vs non-physician). In democratic groups, the physicians practicing in the group are offered the opportunity to become partners or owners of the group, usually after a certain period of employment with the group. Benefits and privileges of partnership range from completely flat structures to tiered based on level of partnership. The structure of the democratic governance can vary in many ways including: who makes decisions to accept new partners, the track to partnership, the vesting period, the cost of the financial buy-in, which aspects of the company a partner owns, profit-sharing, voting power, and the scheduling preferences granted towards partners and non-partners.<sup>23</sup> Democratic groups vary in size, but tend to be local or regional employing <100 physicians with annual volumes <250,000 patients.<sup>24</sup>

Groups and employers vary in their transparency of billing and financial statements. The most transparent groups provide regular reports of what the group has billed under the physician's name and how much the group retains for administrative overhead.<sup>25</sup> Employment contracts for emergency physicians with a group or health system are defined by one of two tax statutes: 1099 (as an independent contractor) or W2 (employee). W2 employees often enjoy more benefits than their 1099 contractor counterparts (such as health insurance and retirement benefits), whereas 1099 contractors typically receive higher salaries. 1099 employees are responsible for their own employment taxes; however, they are allowed significant additional tax deductions for business expenses.<sup>26</sup>

Financial control and ownership of groups can vary widely, often including combinations of physicians or corporate entities, which generally refers to private equity, venture capital, insurance companies, or public shareholders.<sup>27</sup>

## Corporate Investors and Owners

### What is Private Equity?

Private equity (PE) is a broad term to describe activities where investors purchase an ownership stake in companies or financial assets not publicly traded on public stock exchanges.<sup>28</sup>

The private equity investment life cycle begins when a PE firm starts raising money from outside investors.<sup>20</sup> These investments are pooled into an investment fund that operates for a specific period of time; often around 10 years.<sup>29</sup> The PE firm then buys and sells companies with the goal of improving

their performance to increase their value, and then selling them a few years later, within the life of the fund, at a profit.<sup>20</sup> When acquiring companies, PE firms often borrow money to make the purchase in a process called a leveraged buyout.<sup>30</sup> Borrowed money is preferable to these firms, as the borrowed money can increase the potential return on investment as private equity firms can use less of its own capital to acquire companies thereby generating profit on a larger company with a smaller investment, and also provides a tax incentive as the borrowed money reduces a company's tax liability. This is one of the controversial features of private equity investments as the debts taken on by PE firms are owned by the newly purchased company and not the PE firm, thus if the company eventual files for bankruptcy, the PE firm is not responsible for that debt.<sup>29</sup> Private equity returns can be an attractive investment as their returns are often similar to returns from mutual funds that invest in smaller companies.<sup>31</sup>

## Private Equity in Health Care

Private equity investments and buyouts have been present in health care since the 1980s but have been more noticeable over the past two decades. A private equity research firm estimated in 2019 that buyouts from private equity firms involving North American health care workers totaled \$46.7 billion, which was an increase of \$28.6 billion from 2018. In 2019, private equity buyouts accounted for 60% of all health care-related buyout transactions.<sup>32</sup> In a Medicare Advisory Committee Report to Congress, the report detailed the number of private equity funds investments in health care to include retail health, behavioral health and substance abuse centers, hospice centers, and physician practice management groups in specialties such as dermatology, radiology, gastroenterology, and ophthalmology.<sup>20</sup> Health care and health care facilities have become a recent priority for private equity in the United States given the demand for services related to an aging population and extended period of low interest rates prior to the pandemic. Prior to the pandemic, health care was an attractive investment for private equity given the stable, growing demand of health care in the United States, the use of insurance and fee-for-service payments, which meant predictable cash flow.<sup>20</sup>

Private equity is pervasive within health care, even among systems that most physicians and patients believe to be reputable. According to Modern Healthcare's Annual Health Systems Financial Database, the 5 health systems with the largest private equity investments in 2020 were the Kaiser Foundation, Mayo Clinic, Ascension, Cleveland Clinic, and Advocate Aurora Health, with Mass General Brigham being a close sixth. These health systems are all registered as a 501(c)(3) organization and are considered not-for-profit.<sup>33</sup>

## Hospitals

Overall, PE firms seek to generate profits by implementing processes that increase revenues (such as serving more privately insured patients, providing more services especially well-compensated procedures) while decreasing costs (such as taking advantage of economics of scale and reducing labor costs by reducing staffing and decreasing employee compensation, including substituting less expensive clinicians for more expensive clinicians). A cross-sectional analysis performed by the 2021 Medicare Advisory Committee Report to Congress found that private equity owned hospitals tended to have slightly lower costs and lower patient satisfaction scores than other hospitals. MedPAC did not find any statistically significant difference in patient mortality or other quality metrics, but the data on the impact of PE on quality of care is very limited.<sup>20</sup>

## Physician Practices

Physician practices are a prime target for private equity investment, as most physicians have historically worked in small practices, creating a market that is fragmented rather than consolidated; 56% of non-government employed physicians are in a practice of 10 or fewer physicians, making these practices excellent targets for private equity buyouts.<sup>34</sup> While the share of physicians in mid-size practices (11 to 49 physicians) has remained stable, there has been a surge in group practices of 50+ physicians due to increasing integration of physician practices with health systems. Between 2016 and 2018, the number of physicians affiliated with health systems in the United States grew from 40% to 51%; as a result, the private equity firms and health systems are competing for purchases of physician practices thus increasing the pace of physician practice consolidation.<sup>35</sup>

The latest data in EM suggests that private-equity backed physician employers staff 25% of U.S. emergency departments.<sup>36</sup> However, estimating the total number of physician practices fully or partially owned by private equity firms is difficult as many of these transactions are not publicized or protected by nondisclosure agreements.<sup>26</sup> One study found that 355 practices were acquired by private equity firms between 2013 and 2016, accounting for 2% of the ~18,000 practices in the United States, but this number does not account for any practices acquired by PE firms before 2013 or after 2016.<sup>37</sup> Specialty practices most commonly consolidated into private equity investments are family practice, emergency medicine, anesthesiology, and dermatology. Even in the setting of the pandemic, private equity interest in acquiring physician practices has remained high, and this form of corporate investment in medicine will continue to be an issue for the future of EM.<sup>38</sup>

## Moving Forward

### Cause for Concern

Corporate involvement in medical care can create a conflict of interest between financial performance and all the other responsibilities of our health care system, including the patient care, educational, and research missions of EM practice and training.<sup>39</sup> While all health care businesses must generate profit, certain corporate structures may incentivize business decisions at odds with physician and patient well-being. For example, the economics of private equity control might incentivize riskier, more aggressive strategies that are especially concerning given the lack of transparency in health care relative to other industries where private equity invests.<sup>39</sup> While objective data on the impact of private equity or other corporate investors in EM is lacking, more data is available in the nursing home industry. The role of PE in creating poor patient outcomes alongside increased costs to patients and the government in the nursing home industry has led the public and Congress to scrutinize their presence in health care overall.<sup>20,40</sup> More data and more transparency are both needed in order to better understand the impact of corporate investment on patients and physicians in emergency medicine.

### TAKEAWAYS

- When choosing a place of employment, consider the benefits and risks of each type of practice in emergency medicine. Advocate for places of employment that value the protection of physician autonomy and preserve due process rights.
- Educate yourself about the changing practice landscape for emergency physician employment, use this knowledge to determine which employment arrangement will work best for your career.
- The corporate practice of medicine varies from state to state. Know what safeguards are provided from your local and state legislatures in order to protect your autonomous decision-making.



# EDUCATION AS THE NEW BATTLEGROUND

*Kenneth Kim, MD; Carolina Ornelas-Dorian, MD, MPH*

**Graduate Medical Education (GME) and its funding have always been an important consideration in health policy in America.** From the capping of public GME funding in the 1980s to the recent surge in residency program growth, understanding the history of GME and how this history informs current trends will help us in our path to securing the future of resident and patient-focused GME moving forward.

## Why It Matters to EM and ME

GME funding and the trends within residency and fellowship education can have far-reaching effects on the practice of emergency medicine as a whole. Expansion of GME funding has implications for the EM workforce supply and retention, residency practice settings, quality of residency training, and long-term GME financial sustainability.

Since 2010, EM residencies have grown across the U.S. due to changes in the accreditation process, expansion of existing programs, increases in newly accredited programs, and increases in privately funded programs.<sup>1</sup> EM residency spots in Florida have increased 200% compared to 20% across all other specialties. The long-term impact is yet to be determined, but workforce projections have forecast an oversaturation of EM clinicians in urban areas while the need for EM staff increases in rural areas. Privately funded residency programs, for example, could address or exacerbate workforce needs, depending on their location in the United States and the eventual practice locations of their graduates.<sup>2</sup>

Some new GME programs propose they are helping to develop pipelines to practice and drive retention in communities in need. Kaiser Southern California states that a main driver of their residency program is to recruit excellent faculty

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*The changing landscape of GME funding offers opportunities for us, as emergency physicians and as a specialty, to advocate for consistent standards for the training and educational mission across emergency medicine residency programs.*

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through teaching opportunities. About 50% of Kaiser So-Cal residents remain after graduation.<sup>3</sup> HCA Healthcare, which has 300 residencies in 16 states, notes that up to 78% of EM graduates practice in the state where they trained.<sup>1</sup> Kaiser's GME programs include retention practices focused on fostering mentorship and belonging, incorporating direct feedback, increasing feelings of control over one's environment, and providing recognitions and rewards.<sup>4</sup> These organizations advocate that their programs are not simply a matter of short-term economics of a cheaper labor force, but about long-term human resource development.

Expanding sources of GME funding could diversify clinical sites where residents practice and learn. Given the focus on inpatient hospital reimbursement, current GME funding has led to gaps in funding for residency time spent in non-hospital settings, like a poison control center.<sup>1</sup> With broader sources of funding that are not restricted to hospital settings, residents may gather more diverse clinical exposure to different EM practice settings. Several studies have shown that exposure to rural programs increases the odds of practicing in a rural environment.<sup>5</sup> Given that federally funded GME residency spots are disproportionately concentrated in the Northeast,<sup>6</sup> other sources of funding could improve dynamic access to care to underserved and rural populations that better reflect current needs.

A benefit of government funded residency spots is the consistency of funding and educational standards. More private funding may lead to less regulation, less standardization, and poorer quality control if there is little or no oversight from organizations like the ACGME. Similarly, the actual reimbursement for residents could change — leading to higher or lower wages.<sup>7</sup> GME Medicare funding is well established and a long-term source of funding. Non-Medicare sources of funding rely on short-term grants, community resources, and other sources that are not necessarily guaranteed over time. Guaranteeing financial security is important for EM residents to have a financially stable program to complete their residency training.

## **How We Got to This Point**

Funding for GME in America comes from a variety of sources, including public entities such as Medicare, Medicaid, state governments, Veterans Affairs (VA), and Health Resources and Services Administration (HRSA), with some component of private funding that is difficult to measure. Medicare makes up the largest portion of public funding, and its formulas and regulations have been largely static for more than 20 years, which has led to demand for alternative sources of residency funding in a vastly different society and health care market today.<sup>8</sup>

Since its inception in 1965, Medicare, as part of the program's structure, has included payments to teaching hospitals to subsidize the cost of training physicians. It continues to provide the majority of federal funding for residencies today: 71% of federal GME funding comes from Medicare, vs. 16% from the federal share of Medicaid and 10% from the VA.<sup>9</sup> When this funding was established, the goal was to provide high-quality care to Medicare patients, not necessarily to fund the cost of teaching residents in the care of non-Medicare patients. The payment formula reflects this and incorporates the number of residents, "reasonable hospital costs" per resident, and percentage of the hospitals' patients who are covered under Medicare. Hospitals that do not care for a large Medicare population (eg, children's hospitals, safety net hospitals) are at a disadvantage in receiving Medicare funding.<sup>8</sup> These discrepancies are only partially addressed by the Medicaid program's GME funding and the Children's Hospital GME Payment Program (a program run by HRSA specifically designed to cover the gap in funding for children's hospitals), the latter of which only receives ~2% of GME funding, nationwide.<sup>9</sup>

Current Medicare GME funding is divided into two parts. The first is direct medical education expenses (DME), which include direct costs related to supporting residency programs, such as resident and faculty salaries, costs of classrooms and teaching materials, and overhead administrative fees. The second is indirect medical education (IME), which includes payments for the higher costs a hospital may incur in the course of patient care due to the fact that trainees are present. Examples of these costs could include the cost of running additional tests that trainees might order, caring for high-acuity and highly specialized patients, maintaining trauma center status, and increased technological expenses.<sup>10</sup> Hospitals are allocated IME funds to use at their discretion, and there is minimal standardization or tracking. States may supplement Medicare funding for GME with additional state funds, though there are no federal guidelines for how much or even whether states must contribute, leading to variability in funding across the U.S. There is also little to no data on the outcomes or uses of GME funding, leading to further opacity in the entire GME funding process.<sup>11</sup>

In 1997, Congress, with the support of the AMA and AAMC, passed the Balanced Budget Act (BBA), which "capped" the total number of residency spots that CMS would fund at 1996 levels in an effort to address increasing Medicare expenses and concern for a projected oversupply of physicians.<sup>11</sup> This meant that Medicare would not provide additional GME funding for more residency slots to any teaching hospital that was training residents at that time. This initially caused a chilling effect in the growth of residency programs, with the number of residents increasing only ~0.1% between 1997 and 2002.<sup>11</sup> However, there were almost 50,000 more residency slots in 2021 than in 1997, representing a near

50% increase. This increase arises from new teaching hospitals, “above the cap” positions, and extra funding for rural and critical access residencies.

Hospitals that have not previously been teaching hospitals are referred to as “GME-naive” and are not subject to the 1997 Medicare GME cap. Instead, if a GME-naive hospital becomes a teaching hospital, their GME cap is calculated and implemented in the 5th year of their new training program. These “GME-naive” hospitals have a strong incentive to increase the number of residents at their site within 5 years of starting because CMS calculates their training cap after the fifth year; however, this rapid growth can be difficult for many nascent programs.<sup>12</sup> Many “above the cap” positions have been added since 1997, with hospitals self-funding residency slots or obtaining other funding, such as state grants or private endowments. While Medicare-funded spots still greatly outnumber “above the cap” positions, there are around 15,000-20,000 “above the cap” positions, representing 10-14% of the total number of residency spots.<sup>13,14</sup>

The ACA in 2010 attempted to improve rural access to GME funding by establishing rules for redistributing unmatched residency spots for primary care and residency programs with low resident to population ratios.<sup>15</sup> However, these efforts have led to minimal impacts on rural areas thus far.<sup>8</sup>

Many opponents of the GME cap argue that the financial and demographic factors that were represented in GME funding in 1996 are vastly different from those in the modern day. When capped, a majority of teaching hospitals (and thus residency spots) were located in the Northeast, and the cap has limited the expansion of medical education to other parts of the country. Critics of the current system of GME also argue that much training and health care is provided through sites other than traditional hospitals and that funneling most GME funding through Medicare hospital payments places non-hospital specialties and practice environments at a distinct disadvantage.

In order to increase residency spots, there has been an increase in private GME funding. One example is Hospital Corporation of America, a for-profit organization that currently advertises offering more than 300 residency programs in 16 states.<sup>16</sup> Other examples include Kaiser Permanente, a private health care system, that trains approximately 6% of the GME graduates and 11% of primary care graduates in California.<sup>4</sup> Kaiser has teaching affiliations with many academic health centers throughout California, including the University of California system. The monetary value of such private GME funding, as well as that of “above the cap” residency slots at more “traditional” teaching hospitals, is hard to truly know, as much of this funding outside of direct resident salary is mixed into general operational costs, and GME funding data is not clearly reported.

## Current State of the Issue

There were 283 ACGME-accredited EM residency programs as of April 2023. This represents a 30.2% growth in the prior 5 years compared to 2015. For reference, the specialties of internal medicine and general surgery saw a 24.9% and 23.7% increase, respectively. The only specialty with more growth was family medicine, at 31.5%. Compared to prior years, the proportion of programs sponsored by for-profit institutions during this period has increased from 4% to 37%.<sup>17</sup> For further context, the ACEP Workforce Report estimated an approximately 8,000 EM physician surplus by 2030, assuming a 2% GME growth rate annually.<sup>18</sup>

Of note, this trend in the growth of residency positions and EM residents is fluid. In the 2022 Match, 219 PGY-1 positions involving 69 programs were initially unfilled in the Main NRMP Match®, in contrast to 14 unfilled PGY-1 positions involving 9 programs in the 2021 Match.<sup>19,20</sup> The 2023 NRMP Match® initial results were exponentially worse, with 554 spots initially unfilled.<sup>21</sup> While this change seems significant in the face of prior years' growth and has been concerning to some medical educators, there are numerous confounding factors, including the COVID-19 pandemic and the reaction to the 2021 ACEP Workforce Report. It will be important for educators and trainees alike to monitor these trends in the coming years to ensure GME within EM continues to attract the best and brightest to our specialty.

## Moving Forward

The changing landscape of GME funding offers opportunities for us, as emergency physicians and as a specialty, to advocate for consistent standards for the training and educational mission across emergency medicine residency programs, no matter the funding source, and to limit profit-motivated interference in emergency medicine practice and training. Obstacles to these efforts include private interests lobbying for independence in oversight and regulation. Strategies to mediate this opposition could include unified efforts from national organizations such as EMRA and ACEP.

It's crucial that national EM organizations continue their work to secure appropriate GME funding in order to match workforce needs without oversaturating the market. It is important to note that for many years there was previously a projected shortage of physicians across specialties, including in EM, especially in rural and less desirable regions. Due to the needs for better access to well-trained physicians, the preservation and expansion of GME funding has been a top priority for many resident organizations, including EMRA, in the past.<sup>1</sup> Only in recent years has a concern for oversaturation of the labor force in EM led the specialty to reassess our full-throated support of GME funding expansion. It will be important to balance calling for adequate Medicare GME funding without

overexpansion of programs and positions. With an increase in diversity of GME funding sources, it is also critical to promote further transparency in both sources of GME funding and the allocation of funds.

EMRA supports sponsoring institutions securing adequate federal funding of GME and supports independent financing without replacing currently funded GME positions or violating the Match process to train emergency medicine residents. EMRA believes the primary purpose of residency is education before service; therefore, EMRA opposes the sale or commoditization of CMS residency slot funding.<sup>22</sup>

## TAKEAWAYS

- A majority of GME funding comes from Medicare; however, GME funding has expanded to include private sources (eg, Kaiser Permanente and HCA).
- Having GME training programs at a hospital increases reimbursement for the hospital, even in the absence of residency positions directly funded by Medicare, and this funding has been a major factor leading to the expansion of EM residencies.
- Expanding beyond Medicare funding can diversify clinical residency training sites (eg, poison control centers) and promote innovation in retention/recruitment.
- Increases in GME funding and number of training positions can impact the EM workforce both positively (by addressing gaps in care for rural and underserved populations) and negatively (by oversaturating the market with EM physicians).
- Future advocacy efforts should include ensuring standardized residency training and educational mission (no matter GME funding source), limiting profit-motivated interference in residency training and patient care, promoting transparency in GME funding sources and allocation, and ensuring EM workforce needs are met without oversaturating the market.



# EMERGENCY MEDICINE OUTSIDE THE ED

Jose Reyes, MD; Adnan Hussain, MD

**For the past 20 years, emergency departments have been faced with increasing patient volumes and overcrowding, leading to poorer outcomes for patients and worsening work environments for physicians and staff.** Many emergency physicians are now looking outside of the physical emergency department in order to alleviate stress on our EDs while providing high-quality care to patients.

## Why It Matters to EM and ME

The specialty of emergency medicine was born of the need for highly trained physicians with expertise in the diagnosis and treatment of undifferentiated acute problems and threats to life and limb. To assure this care is provided, emergency departments need access to specialized equipment and 24-7 diagnostics. We will always need hospital-based brick-and-mortar EDs, but the current climate of health care – particularly for emergency medicine – means it's also time to examine how we can bring our skills beyond the four walls.

## How We Got to This Point

Before the 1960s, patients seeking care for unscheduled, emergent issues were seen in hospital rooms staffed by a variety of physicians in different stages of training in any type of medicine, from pathology to surgery.<sup>1</sup> Additionally, and importantly, pre-hospital care was unorganized and unregulated, with many funeral homes providing medical transport with the assistance of untrained staff. The 1960s saw a confluence of events that led to the rise of emergency medicine as a specialty and for prehospital care standards, set by the Federal Highway Safety Act, along with the innovation of CPR as a resuscitative measure.<sup>1</sup> With the implementation of EMTALA in the 1980s, hospital-based emergency

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*We must find ways to provide acute, emergent, and urgent care without sacrificing access for the vulnerable populations we serve. Expanding the methods and locations by which we show up for patients, 24/7/365, must be a priority.*

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departments evolved into the safety net for our society; the place where doctors serve “anyone, anything, anytime.” From 1997 to 2016, emergency department visits increased by 60%.<sup>2</sup>

Before the COVID-19 pandemic, our EDs and our specialty were already at a breaking point, with 50% of emergency departments experiencing overcrowding in 2015 and one-third having to divert ambulances.<sup>3</sup> It was in this state that we found ourselves entering the COVID-19 pandemic. Meanwhile, the U.S. population is aging, which means EDs are frequently seeing a larger portion of older and more medically complex patients,<sup>1</sup> along with people who – because of a broken insurance system, financial hardship, or lack of primary care access – simply forgo care until a crisis event.

## **Current State of the Issue**

Just as a confluence of factors led to the creation of EM as a specialty, a confluence of factors is gathering to add “anywhere” as a fourth tenet of EM.

Many emergency physicians experience the strain on emergency departments firsthand. From evaluating ill-appearing patients in hallways to examining, treating, and discharging patients from the waiting room, our current system is often not conducive to efficient and effective care of patients. Before and during the pandemic, 50-60% of hospitals experienced overcrowding.<sup>3,4</sup> The effects on patients are apparent: delays in assessment and care, increased rate of patients leaving without being seen, and increased mortality.<sup>5</sup> Less apparent are the systemic effects, such as increased inpatient length of stay beyond the already prolonged emergency department length of stay, which then further worsens crowding. Constantly dealing with these challenging working conditions is burning out dedicated emergency physicians. Change is needed now to minimize deleterious effects on both patients and staff. Ours is a specialty founded in and molded by the gaps left in the medical system, and it is through our innate flexibility that our field can further adapt to meet the changing needs of our patients.

Emergency physicians are the experts in acute care, but how we deliver that care is evolving. From providing acute care in different settings to providing pre- and post-acute care, the expansion of our practice will not only increase access to care but simultaneously decrease strain on hospital-based brick-and-mortar EDs. This could affect future practice in one of two ways. For some, this may serve to diversify a physician’s work. The ED is a physically and cognitively demanding workplace. Instead of working solely in the emergency department, some physicians may be able to split their work between standard ED shifts and novel settings, such as telehealth, mobile clinics or hospices. For others wanting to work exclusively in a traditional ED setting, they will interact with patients

who may have access to emergency physicians before and after an ED visit, broadening the methods by which patients can receive acute care.

The purpose of innovating the practice of emergency medicine is to increase access to acute care while also offering practice models that provide new venues for accessing the expertise of emergency physicians. Community paramedicine is one such example. Using this model, paramedics can assess, refer, and educate patients at-home or in residential facilities, often with remote support from emergency physicians.<sup>6</sup> Studies evaluating community paramedicine have demonstrated improved health outcomes and decreased emergency department visits, with patients experiencing better diabetic and hypertensive control while also decreasing transport to EDs up to 78%.<sup>6</sup> Patients who were transported by community paramedicine providers had higher rates of admission compared to those transported by traditional paramedics and were admitted more frequently, indicating community paramedics can accurately identify patients needing a higher level of care, without increased mortality or a subsequent visit to the ED within 7 days of evaluation. In a separate study focused on targeting high ED utilizers comprised of elderly patients with multiple comorbidities, ED transports and 911 calls decreased by nearly half.<sup>7</sup>

Telehealth, or the use of audio-video technology to remotely assess patients, allows emergency physicians to provide remote care, either through direct connection with patients or by supporting nonphysicians providing care in remote or out-of-hospital settings. Acute care telehealth may simply allow physicians to recommend transport to an emergency department, but with appropriate resources, can also allow physicians to order tests and subsequently follow up to discuss the results with appropriately selected patients.<sup>2</sup> One prospective study found that 3 in 4 patients who utilized telehealth for acute problems had their concerns resolved in one visit while simultaneously decreasing costs, serving as a proof of concept for the utility of the service.<sup>8</sup> Additionally, other EMS systems have investigated the use of audio-video conferencing for patients being evaluated by paramedics responding to an emergency services call.<sup>9</sup> While traditional payment models for EMS require transportation to the hospital for the EMS agency to be paid, alternative payment models are now being piloted such as the CMS Emergency Triage, Treat and Transport (ET3) to still provide payment in the absence of transport.<sup>10</sup> For higher acuity patients requiring transport, this can serve as a real-time method to provide improved treatment en route and ideally shorten ED wait times for those who do require further emergency department evaluation and treatment.

Beyond providing care at home, emergency medicine can benefit from emphasizing and prioritizing the development of urgent care and mobile facilities to broaden the access to care for lower acuity complaints, particularly in underserved communities. In one study, proximity to an urgent care center was shown to reduce patient presentation to academic emergency departments.<sup>11</sup> An

urgent care center within 1 mile of patients reduced presentations for low-acuity complaints to academic emergency department, and that effect compounded by 1% for each month the urgent care was open over a 2-year period.<sup>11</sup> As the specialists in acute unscheduled care, emergency physicians are uniquely suited to practice in urgent cares as well as other environments where unscheduled care is delivered, such as on cruise ships, at events and in disasters.

In recent years, the medical community has focused on increased access to care for the underserved, studying street medicine and mobile clinic solutions. Street medicine is the practice of providing clinic to provide care for unsheltered individuals, whether in a mobile or permanent clinic.<sup>13</sup> Mobile clinics can also serve other groups struggling with access to care, such as recent immigrants or the uninsured. In one study, homeless patients who utilized dedicated clinics for the unsheltered had an 8% reduction in inappropriate use compared to those who used hospital-based clinics; they were also less likely to require admission, indicating an improvement in clinical outcomes in addition to being less likely to present for social needs such as food or housing.<sup>14</sup> Mobile clinics' patient-centered focus and utilization of community health workers has been shown to improve outcomes by fostering trust and more shared decision-making among patients.<sup>14</sup> One mobile clinic in Southern California focused only on serving children with asthma in underserved communities; it decreased ED visits, while also increasing symptom-free days for patients, suggesting utility beyond simply managing acute exacerbations of illness.<sup>15</sup> Due to the breadth of our training and our familiarity with treating underserved patients, emergency physicians are well-suited to practice in these settings and may find the new environment to be uniquely fulfilling.

Rural populations also struggle with health care access. In the early 2000s, legislation was passed to prevent the closure of rural hospitals by providing the designation of "Critical Access Hospital." This designation appropriated increased funding to rural hospitals with 24/7 access to emergency services. Despite receiving additional funding, many rural hospitals have nonetheless closed, leading to a gap in the availability of emergency services by EM-trained physicians.<sup>16</sup> One proposed model of providing emergency services is by promoting the development of free-standing emergency departments, believed to be a more cost-effective manner of providing emergency care.

As the U.S. population ages, the medical complexity and average acuity level of emergency visits is increasing.<sup>17</sup> Even with mobile medicine, complex patients with acute needs are likely to require intensive treatment and stabilization. One method by which our care delivery can evolve for them is by emergency physicians providing home-based care for these patients. Two specific examples include hospital-at-home care and home hospice care.

Hospital-at-home, per the American Hospital Association, is a care delivery model that enables “some patients who need acute-level care to receive care in their homes, rather than in a hospital. This care delivery model has been shown to reduce costs, improve outcomes and enhance the patient experience.”<sup>18</sup> Hospital-at-home interventions keep inpatient beds open without sacrificing outcomes for those with chronic illnesses. In these programs, patients with acute needs are closely monitored at home with remote monitoring equipment and home visits by nurses and physicians; in some cases, the physicians may evaluate the patient using telemedicine. In a recent meta-analysis, hospital-at-home programs did require a longer treatment time but were associated with fewer readmissions and decreased need for long-term care, a common complication of in-hospital admissions.<sup>19</sup> In addition to emergency physicians managing acute illness at home, emergency physicians are becoming more engaged in palliative care as a method of decreasing emergency department visits for patients with multiple comorbidities in the later stages of life.<sup>20</sup> Palliative care fellowships now are open to EM-trained physicians,<sup>21</sup> as ED-initiated palliative care can result in better outcomes and decreased emergency department visits. Many emergency physicians find palliative care and hospice care to be a gratifying and meaningful way to expand their practice.

## Moving Forward

Emergency medicine fills gaps left by an often antiquated health care system by evaluating and treating all comers to our emergency departments. Crowding and boarding are breaking the safety net that is the ED. To accommodate the needs of our patients without compromising the longevity of emergency department staff, it is evident we must change the way we practice emergency medicine.

With many mobile clinics and street medicine-based initiatives operating solely on philanthropy or grants, we should advocate for funding and compensation from payers for care provided through these programs. Telemedicine, another way to expand coverage, would benefit from multistate telehealth licensure to allow for emergency physicians to provide care across state lines.<sup>22</sup> Standardized regulations for freestanding EDs also could increase the safety net while offering a different practice model for physicians.<sup>23</sup> All of these goals require advocacy at the institutional, state, and federal levels.

We also must advocate within the health care system (and academic medicine) to promote the benefits of broadening care beyond the four walls of our EDs. From increasing education on palliative care to broadening awareness of EMS-based interventions such as community paramedicine, we can strengthen the knowledge of graduating physicians and physicians in leadership roles to promote programs that can improve quality of life for patients while simultaneously resulting in less utilization of the ED itself.

We must find ways to provide acute, emergent, and urgent care without sacrificing access for the vulnerable populations we serve. Expanding the methods and locations by which we show up for patients, 24/7/365, must be a priority.

## TAKEAWAYS

- The future of emergency medicine will involve emergency physicians practicing outside of the traditional hospital-based brick-and-mortar ED.
- 50-60% of emergency departments are faced with overcrowding, leading to poorer outcomes for patients, higher health care costs, and increased burnout for medical providers.
- More elderly and medically complex patients lead to strain on emergency departments, indicating interventions beyond increased access to primary care are necessary to relieve the current strain.
- Initiatives that increase access to care for vulnerable populations have been proven to safely decrease non-emergent ED visits.
- Emergency physicians are well suited to provide care to patients in their homes through ED-initiated hospice care or hospital-at-home treatments, leading to better quality of life for patients while avoiding the complications associated with hospital admissions and keeping inpatient beds available.
- Advocacy on legislation improving physician compensation for novel initiatives is necessary to allow for widening of the safety net emergency medicine provides.
- Promoting education on these initiatives is necessary to have a physician workforce prepared to engage and thrive in the new face of acute care.



# LEADING OUTSIDE THE WALLS: IMPORTANCE OF LEADERSHIP SKILLS

Tuong Pham, MD; Thuy Nguyen, MD; Steven Nazario, MD

**From the earliest stages, our training in emergency medicine focuses on leadership in the emergency department.** From making decisions alongside a multidisciplinary team regarding routine patient care to leading resuscitations at the head of the bed, these skills are developed and constantly fine-tuned throughout an EM residency. The same leadership abilities that help us navigate the intricacies of the ED can be transferred outside the walls of the department and allow EM physicians to participate and trailblaze in new arenas.

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*Learning to speak publicly and deliver information to a diverse crowd is a skillset most of us never received formal training on, but as the old adage goes, experience is the best teacher, and it is never too early to begin.*

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Health outcomes are the result of the complex interplay of socioeconomic status, health policy, and health care delivery systems – rather than solely the result of medical interventions.<sup>1</sup> To improve health outcomes on a broader scale, physicians should seek out and assume leadership roles within the health care system, academia, politics, and their community.

## Why It Matters to EM and ME

There are numerous compelling reasons for EM physicians to lead outside of the ED. While the number of EDs in the US is dropping as hospitals close, the number of ED visits is rising even faster than the US population is growing.<sup>2</sup> Under Medicaid expansion and the Affordable Care Act (ACA), the number of ED visits continued to rise.<sup>3,4</sup> While COVID-19 may have temporarily decreased ED visits, it also degraded the ability of EDs to function smoothly, negatively impacting the well-being of emergency physicians and patients. Many of the advocacy issues highlighted throughout this book highlight the need for emergency physicians to choose leadership positions.

EM physicians are also uniquely qualified to lead in hospital and health system committees and administrations, as they interact extensively with each service

in the hospital, providing a broad overview of the structure and function of the organization. Due to their position on the front lines of medical emergencies, EPs are sought after to provide expertise during bio-terrorism, natural disaster, trauma, and crisis events. These opportunities for leadership should be seized so that we can best advocate for our patients and profession beyond the bedside.

## **How We Got to This Point**

In the current context, it is difficult to believe that most hospitals did not have anything akin to what we now recognize as an emergency department. The “emergency room” was often a place for patients to meet their primary care doctor when the patient needed urgent treatment necessitating admission to the hospital. EM has grown substantially over the past 60 years. Born out of the need for emergency care and emergency-specific training, we have established EM as a specialty with specialized residency training and established an official pathway to board certification through the American Board of Emergency Medicine (ABEM).

We’ve also established numerous organizations, including the American College of Emergency Physicians (ACEP) and other professional organizations such as the American College of Osteopathic Emergency Medicine (ACOEP), the Emergency Medicine Residents’ Association (EMRA), the Society for Academic Emergency Medicine (SAEM), the American Academy of Emergency Medicine (AAEM), and Council of Residency Directors in Emergency Medicine (CORD-EM) to represent and advance our specialty. The success of establishing EM as a specialty was achieved because of the initiative and leadership of like-minded individuals across the country who advocated for standardized care for patients with acute, unscheduled medical needs.

American Medical Association (AMA) guidelines call for physicians to “advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human wellbeing.”<sup>5</sup> It is essential that physicians engage in leadership at all levels to effect change in health care for a larger population than they can personally treat.

## **Current State of the Issue**

Our emergency department patients frequently come to us with illnesses and injuries that demand a broader solution than just treating an individual patient at the bedside. Organized EM leads the way on issues affecting our patients like gun violence, opioid use disorder and motor vehicle safety, leading to improvements to protect society outside of the hospital walls.

## Moving Forward

While these huge societal issues may feel daunting, there are many opportunities to be part of the solution to better support our specialty and improve health outcomes for the broader population.

### Medical Education

Leadership can begin at any level, and there are many opportunities to get involved as early as medical school. In particular, Emergency Medicine Interest Groups provide programming that is designed to increase exposure to EM while in medical school, as well as address vital questions for those who are considering EM for their next step of training. Beyond leadership opportunities within these interest groups, they are also an excellent way to become involved with state chapters of ACEP and expand one's network.

Peer-to-peer teaching from senior residents to junior residents is another way to be involved in education. Becoming a chief resident provides an excellent opportunity to teach and make changes to the curriculum. Many physicians eventually pursue a medical education fellowship to prepare for roles in directorship and professorship.

### EM Professional Organizations and Hospital Leadership

To start, learn about the governance structure of the hospital or organization where you hope to pursue leadership opportunities. Familiarizing oneself with the process of leadership appointment or election and having meaningful conversations with current leaders can be informative.<sup>6</sup> In emergency medicine, multiple organizations offer a plethora of leadership opportunities at state, regional, and national levels - including an initiative to ensure ACEP state chapters offer a resident position in their leadership structure. (*Find that state leadership pipeline through [www.emra.org](http://www.emra.org).)*

Most hospital and medical school committees actively seek participation from students and residents. This is a great way to observe how meetings are conducted and how agendas developed and followed, in addition to being an opportunity to develop relationships with people who may then serve as mentors. Committee work often leads to getting asked to take on special projects or prop up lagging ones.

## Public Health/Health Policy Advocacy

Advocacy starts at many levels. At the individual level, physicians should advocate for each patient when needed. This may include things like arranging appropriate outpatient follow up with specialists for patients without insurance or encouraging harm reduction education for patients and staff to better care for patients with substance use disorder or homelessness. At the institutional or corporate level, physicians can lead the effort to address boarding/overcrowding issues, or work to understand the causes of high utilization in certain populations. There are many organizations for medical trainees at different levels to engage in advocacy at the local and national scale, including ACEP, NEMPAC, AMA, state medical societies, AAEM, and more. Emergency medicine trainees can learn the basics of health policy and advocacy by joining EMRA Health Care Policy committees and attending the annual ACEP Leadership and Advocacy Conference in D.C.

Recently, EMRA adopted the Mental Health and Emergency Medicine Providers policy, which was proposed and written by both medical student and resident members of EMRA. The policy aims to set the standards and goals for mental health support for emergency medicine residency programs.<sup>7</sup> At a federal level, Congress passed the Dr. Lorna Breen Health Care Provider Protection Act in 2021 in an effort to support physician mental health after years of collaborative efforts on the subject. A recent ACEP Now article chronicles the journey of the bill, involving that extensive work by a large number of physicians, and sheds light on the opportunities for physicians at different training levels to participate in future health care policy efforts.<sup>8</sup> Getting involved in advocacy work can help physician trainees learn about critical legislative issues and prime them for future advocacy roles. Two current examples are Dr. Amish Shah, an EM physician and State Representative in Arizona, who recently detailed his journey and experience during a webinar hosted by the EMRA Health Policy Committee<sup>9</sup> and Dr. Arvind Venkat, a recent member of the ACEP Board of Directors who is now serving as a State Representative in Pennsylvania.<sup>10</sup>

## Community Leadership

In addition to the national organizations, there are state and regional versions with similar needs and agendas. These are fertile ground for younger professionals eager to get busy working on solutions for all manner of thorny societal concerns.

Apart from EM-specific organizations, local newspapers, media outlets, and social media often seek representatives to lend their voices and perspectives

regarding current events – particularly those related to public health. When hurricanes or other natural disasters strike, news outlets come looking for EM clinicians who can provide advice and recommendations for the general public. As our recent pandemic experiences have taught us, much of the public is hungry for expert advice, and EPs are well-suited to providing just that. Learning to speak publicly and deliver information to a diverse crowd is a skillset most of us never received formal training on, but as the old adage goes, experience is the best teacher, and it is never too early to begin.

## TAKEAWAYS

- Seek opportunities to volunteer in one of our many EM interest groups.
- Attend a regional or national meeting.
- Join a hospital committee and become an active participant.
- Listen to podcasts or read books on the topic of leadership.
- Take advantage of opportunities such as the EMRA/ACEP Leadership Academy and the EMRA Health Policy Academy to learn about leadership and the health care system.
- Consider asynchronous, online education for additional training, including degrees such as Master's in Business Administration and Master's in Public Health.
- All emergency physicians benefit when leaders throughout our health systems, in our legislatures and in the media are emergency physicians.
- Leadership doesn't have to be "big L" leadership – you can start by taking part in a committee in your hospital, state/national medical organizations or local news appearances – seize opportunities that become available.





# ALL POLITICS IS LOCAL

*Kira Gressman, MD; Nikkole J. Turgeon, MD;  
Nicholas P. Cozzi, MD, MBA; Puneet Gupta, MD, FACEP*

**Emergency physicians are uniquely positioned to be powerful voices in health policy.** But to be effective advocates, we must understand health policy history and appreciate the various state and local structures where policy lives and grows. This will equip the next generation of emergency physician leaders with applicable and time-tested strategies to generate patient-centric policy changes.

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*Taking that first step into the world of health politics can feel daunting. Look first in your own backyard. Health policy changes made at a local level can have the strongest impact.*

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## Why It Matters to EM and ME

Because EM serves as a social safety net, emergency physicians are often the first to see downstream effects of policy. Seeing policy's direct impact on our patients is exactly why emergency physicians make powerful local voices. Bearing witness to harmful effects of policy can inspire action through advocacy and health policy.<sup>1</sup> Policies that constrain physicians' ability to act in accord with their individual and professional ethical values can result in moral distress and lead to burnout.<sup>2</sup> Being active in policy can empower emergency physicians to stand up not only for the welfare of our patients but also for ourselves.

Medicine, especially EM, is inextricably linked with politics that affect the health of our patients, ourselves, and our ability to practice. In 2001, the AMA adopted the Declaration of Professional Responsibility - an oath by which 21st century physicians reaffirm and uphold medicine's social contract with humanity. This oath included the commitment of all physicians to "*advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.*"<sup>3</sup> Advocacy through policy is a core tenant of our jobs and a skillset worth investing in at all levels.

## How We Got to This Point

Medical care in our society does not occur in a vacuum and, unfortunately, has never been apolitical. The American Medical Association (AMA) was founded to regulate medical education and licensure in order to raise professional standards. By 1901, the AMA had grown to become a confederation of local and state medical societies that represented the majority of delegates at the national AMA conference.<sup>4</sup> The AMA House of Delegates serve as liaisons between the AMA and grassroots physicians. The delegates are a key source of information on programs and policies of the AMA.<sup>5</sup> The formation of the state medical societies resulted in an explosive period of growth for the AMA, and its members accumulated political power and financial clout.<sup>4</sup> Paul Starr writes in his book “The Social Transformation of American Medicine,” that physicians “had a lot of cultural authority” and were not shy about using their community contacts to shift public opinion.<sup>6</sup>

Over the next several decades, scientific discovery and academic advancements spurred the formation of new specialties and the creation of corresponding specialty medical societies. The role of specialty societies is to advocate for policies specifically related to patients within that specialty. As these societies grew, the historic majority of state delegate representation dwindled to approximately half of the delegates to the AMA.

In 1968 the American College of Emergency Physicians was founded as physicians worked to attain specialty board recognition. Four years later, the AMA recognized emergency medicine as a specialty,<sup>7</sup> and in 1979 the American Board of Medical Specialties approved the American Board of Emergency Medicine to be the certifying agency for the new specialty. Unlike most other specialties, EM arose out of a progressive social demand for services linked to the moral and ethical aspects of providing care for poor and uninsured people.<sup>8</sup> In 1986, the egalitarian mentality of EM, “*take anyone, with anything, anytime,*” became more than a philosophy with the passage of the Emergency Medical Treatment and Labor Act (EMTALA) signed into law - in essence creating a federal right to emergency care for all people in the U.S.<sup>8</sup>

Today, EMRA and ACEP are allotted delegates who represent EM as a specialty to the AMA. This relationship seeks to be an avenue where the greater emergency medicine specialty as a whole is advocated amongst the house of medicine. To better understand this interplay, let us use the ACEP workforce study report as an example.<sup>9</sup> At the AMA, advocacy efforts to expand residency positions are taking place. Emergency medicine is undergoing a transformation with workforce supply and demand economics taking center stage. Delegates at the AMA were able to explain the needs of EM and advocated for targeted expansion of residency positions. Being able to represent the needs of the specialty is invaluable and imperative.<sup>10</sup>

You might be wondering why is it important to understand this history to participate in advocacy or policy now? One reason is because these organizations are still operating in the political arena and are often the main ways for someone to get involved in health policy and advocacy. For example, the AMA is among the top five lobbying groups in the U.S.<sup>11</sup> Understanding the historical context and power dynamics of health policy organizations will help you be a better advocate.

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***“Data informs, but stories persuade.”***  
**– Arvind Venkat, MD<sup>3</sup>**

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## **Current State of the Issue**

Let us consider how organized medicine functions within state and federal policy more broadly.

### **Comparing State versus Federal Policy**

It is first important to compare state versus federal policy and how they interact. One of the most glaring distinctions is their constitutional scope. State level policy is more granular whereas federal is broader.<sup>1</sup> Many topics have a state and a federal component and the lines may become blurred. Consider Medicaid, where funding is set at federal level but decisions on expansion occur at the state level.<sup>10</sup> If federal and state laws are incongruent, the federal law overrides. A state cannot create a law adding restrictions to an existing federal policy, but states can write laws for additional freedoms. If an issue does not have a corresponding federal law, policy automatically defaults to the state level. One timely example is the Supreme Court overturning *Roe v. Wade* (410, U.S. 113), effectively deflecting abortion legislation to states. If a state policy exists, this becomes the active law at the state level. This remains true even if it is an old law, since state laws are not typically removed.<sup>1</sup>

Justice Louis Brandeis inspired the common phrase, “*States are the laboratories of democracy.*”<sup>12</sup> Policies are often trialed at the state level before implementing a model on a federal scale. For instance, the Affordable Care Act was modeled from policy first established in Massachusetts.<sup>13</sup> In a crisis, an issue may need to quickly jump to the federal level - take PPE access during the COVID-19 pandemic, for example.<sup>14</sup> Other times, a particular issue might get stuck at an impasse federally or there is a concern that a federal approach will infringe on states’ rights. In these cases, policymaking falls back to the states. One example is tort reform that would involve enacting legislation to limit the impact of medical malpractice litigation on physicians. For years, federal legislators have resisted efforts to enact medical tort reform, preferring to leave those decisions to the states. Advocacy efforts have likewise evolved, and resources have shifted from federal tort reform advocacy to state tort reform advocacy. When switching

between levels of policy or geography, it is important to revisit the “ask” and evaluate how your approach should change.<sup>1</sup>

The timelines of state vs federal policy also differ. State level changes may occur more quickly, sometimes on the order of months to a year (of course, not every issue sees rapid change).<sup>14</sup> Each state’s legislature has a unique schedule. The majority of states pass new bills over designated months each year, most frequently from January to June, while others have a year-round legislative schedule.<sup>15</sup> You should be aware of your respective state’s policymaking schedule and utilize your specific issue’s network to know when there is legislative activity.<sup>14</sup> Quick policymaking can be an advantage if the legislation addresses your community’s needs; it can also be negative if harmful legislation is passed rapidly.<sup>14</sup> Federal policy, on the other hand, can take much longer, on the order of years. Consider the question of universal health care - this has been revisited by multiple presidential offices since the AMA campaigned against Truman’s proposal in 1950.<sup>1,16</sup> There is a significant amount of federal red tape; once something is implemented nationally, it becomes very challenging to remove or amend it.<sup>14</sup>

Equity in health policy is also different at each level. At a local or state level, a policy can specifically address a community’s unique needs. In rural states, a few voices may actually have a larger impact. While a federal level can be used to protect rights broadly, making a policy equitable becomes much more challenging when trying to take into account the variability across such a large population and geography.<sup>14</sup>

## **Relationship Building**

Building relationships is a key piece of policy work, at all levels. However, it is much easier to do so at a local or state level where you can readily schedule meetings with legislators and provide insight about the unique needs of your patients, who are also their constituents. It is more difficult to build deep relationships at a federal level.<sup>13</sup> The majority of health policy issues are regulated at a state level.<sup>19</sup> While Washington, D.C., gets more press and can seem more glamorous, we can make the biggest impact locally.<sup>13,17</sup> This is where personal narratives shine, where we have meaningful relationships and networks, and most closely see the impact of policy changes.<sup>18</sup> Any advocacy that you can keep local, do so.<sup>10</sup>

Relationship building is not limited to just the legislators but an extensive group of individuals including constituent groups, lobbyists, staff, legislators, regulators, and more. At the local and state level, ACEP state chapters work with groups like state medical societies, departments of health, local community organizations, and constituents. Additionally, approximately 60% of ACEP state chapters have lobbyists.<sup>14</sup> While not essential, lobbyists are effective because they are policy

experts and understand how to navigate the system. Lobbyists can facilitate networking, set up meetings, and provide topic resources. ACEP is aware of the chapters without lobbyists and provides them with additional support.<sup>13,14</sup>

It is often useful to join forces with the state medical society because they will also have resources available. When state ACEP chapters have similar issues, they can also communicate with the ACEP Director of State Chapter and State Relations who works to ensure ACEP state interests are represented, connect state chapters on similar issues, and provide resources such as assistance with writing testimonies.<sup>14</sup>

## How to Be Effective in Health Policy Advocacy

We have established that emergency medicine policy advocates can be most effective at a local level. Below are strategies gathered from emergency physicians involved in policy on how to do it well.

**Be informed.** Know the basics and know your limits. *“Describing policy perspectives to legislators is like explaining medical issues to a patient.”* Balance helping them understand the issue without being condescending or overly simplistic.<sup>18</sup> Recognize that you may not be a topic expert; find someone who is and advocate alongside them.<sup>13</sup>

**Share stories and anecdotes.** You are advocating for your patients; ensure that your narrative reflects that and be prepared to explain how your policy position represents what is best for your patients.<sup>10,19</sup> Keep a list of anecdotes that can be used for testimonies later.

**Find your networks** and be hyper-aware of your community. Who else is already involved in your issue? Who else will be impacted? What has already been done? Identifying existing efforts and networks to join is easier than reinventing the wheel. Talk with community members and organizations to understand their perspective and whether they believe a proposed policy will have a desired impact. Different partners may have varying ways to approach the issue.<sup>18</sup>

**Define your boundaries** and play the long game. Understand at what point you are prepared to draw a line and lose completely. Also, as stated by Dr. Arvind Venkat, “recognize when it is important to compromise to give the opposing side a win that also functions as a win for yourself.”<sup>13</sup> Do not let perfection be the enemy of the good.

**Strategic timing is crucial.** What other factors are playing a role in the timing of a bill or issue? “It is a skill to recognize when something should be delayed,” or when it is the right time to revisit an issue.<sup>1</sup>

**Tailor your points** to your audience. A proposed policy change may look the same in different states, but the arguments underlying them might be different.

Understand the goals and priorities of your legislators to better frame your arguments, anecdotes and approach.<sup>17</sup>

**Look for opportunities** to bridge ideas together into a larger product. Is there a way to add one issue into a larger, broader bill? Take advantage of these opportunities because they can increase the chance of advancing your issue.<sup>1</sup>

**Be prepared to work across the aisle.** While it is fine to have personal opinions and political affiliations, you can be most effective in policy if people know you are willing to listen and engage with people who might think differently than you.<sup>14</sup> Many health policy issues are an opportunity to garner bipartisan support and this is often what is needed for it to pass. If you are working on a wedge issue, understand the opposing side's thinking and decide how best to center the narrative around what is best for the patient.

**Build and cultivate relationships** – before there is a crisis. “A lot of times, having the relationship will trump partisanship.”<sup>11</sup> Relationships with your community networks and state legislators do not happen overnight - it takes time and patience. You want to develop longitudinal relationships with people so that when bad legislation or a policy emergency arises, they will be more likely to listen to you.<sup>14</sup>

## Moving Forward

The Code of Ethics for Emergency Physicians in EMRA's Policy Compendium states, “Support societal efforts to improve public health and safety, reduce the effects of injury and illness, and increase access to emergency and other basic health care for all.”<sup>20</sup> Being health policy advocates is one of the most impactful ways we can do that.

Of course, there are many challenges. Sub-optimal bills become law. We can lose advocacy battles. When this happens, it is imperative to maintain relationships with legislators; you may want them to revisit the issue later or continue working with them as an advocate for other important issues. Start collecting data and stories of how you and your patients are impacted. After time has passed with that legislation in place, come back with new information and make your case.<sup>14</sup> Other times, no legislation is passed when it needs to be. Consider mental health access. In the state of Washington, there was a set of legal and legislative victories almost a decade ago that seemed primed to improve emergency mental health resources. Years later, nothing new has passed and the state ranks very low for mental health care resources compared to other states.<sup>18</sup> When these obstacles occur, we must be persistent and continue moving forward - “Not doing anything is worse.”<sup>18</sup>

The path to being an emergency medicine advocate will be different for everyone. Regardless of where you start, the journey is worth the challenge. If

you are looking for a group to join, EMRA, ACEP, state ACEP chapters, and the AMA all have active advocacy activities and interested groups. As you consider a group, look for the mentors and opportunities to learn from them. Take the opportunity to share your passion or work as well. Join those groups and become an advocate on an issue by visiting with legislators. If your passion is there for federal advocacy, consider participating in ACEP's annual Leadership and Advocacy Conference in Washington, D.C., and help represent your state with other emergency physicians. Regardless of the avenue, educate yourself on the issues that are important to you and your patients.

Taking that first step into the world of health politics can feel daunting. Maybe you feel overwhelmed not knowing where to start. Never let concerns about your age or level of experience prevent you from getting involved. Legislators want to hear from us! No matter your level of training, you have something to bring to the table.<sup>10</sup>

## WHAT'S THE ASK?

- Health policy advocacy is a core tenet of EM's history and ethics.
- Emergency physicians can and should play a key role in mitigating health disparities through health policy advocacy.
- Understanding the processes and actors for local and federal health policy, as well as the history of organized medicine, is helpful to be a strong health policy advocate.
- Health policy changes made at a local level can have the strongest impact.
- Effective health policy advocacy is grounded in powerful storytelling and cultivating relationships with local legislators.





# PROCESS MATTERS: FROM LOBBYING TO LAW

Cole Ettingoff, MPH; Hannah Gordon, MD, MPH

## **Effective advocacy requires knowing how political decisions that impact emergency medicine are made and who makes them.**

The process of developing laws and federal rules can be lengthy and complex, but a basic understanding of the process can significantly increase your effectiveness.

## **Why It Matters to EM and ME**

Perhaps more than any other specialty, emergency medicine is impacted by decisions made in the political arena. From funding and other resources to social determinants of health and access to alternative methods of care, the emergency department is the front line of where many legal, regulatory, and policy changes take effect. As physicians who see so many societal problems up-close every day, emergency medicine physicians have – since the founding of the specialty – had a strong interest in public policy.<sup>1</sup> Advocacy work can be exhausting. Busy physicians have limited time and energy to make an impact. In a world where social media and other technologies make it easier than ever to amplify your voice, it becomes important to speak clearly and to the right audience. In doing so, you can maximize your impact and effectiveness.

So, what does that mean? To start, effective advocacy requires understanding the root of the issue you care about, what you want to change, and who has the power to change it.

## **How We Got to This Point**

You have probably heard the term “federal government” used to describe the national level government based in Washington, D.C. But why is it federal and why does that matter? The federal government represents a federation of states.

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*In a world where social media and other technologies make it easier than ever to amplify your voice, it becomes important to speak clearly and to the right audience. In doing so, you can maximize your impact and effectiveness.*

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While the strength of the national government has grown significantly since our nation's founding, it is important to remember that unlike some countries, the States in the United States are not mere administrative divisions of the national government. While they relinquish certain powers to the federal government via the Constitution, they retain many powers. National advocacy campaigns are often targeted towards the federal government, but many issues that impact patients the most are governed at the state level. It is worth noting that the relationship between state and local units of government like cities, counties, towns, or parishes varies significantly by state and even within a state. Your state constitution likely has a section on home rule that elaborates on the specifics.

## **Current State of the Issue**

So how does this federal system impact health policy? The powers of the federal government at times can be quite limited. For example, the federal government does not license physicians, license hospitals, directly provide social services such as homeless shelters, or make laws governing issues such as domestic violence or access to care. Instead, the federal government sets policy through extensive funding coupled with detailed implementation rules. The large national health insurance plans, like Medicare and Medicaid, with their large rules for funding, often become de facto requirements nationally. Between Medicare, Medicaid, Tricare (health insurance for the military and their families), Federal Employees Health Benefits Program, veterans' programs, the Indian Health Service, the Bureau of Prisons, and more, there is no denying the federal government has huge financial influence on the health industry. That is before even considering funding for research, the approval and regulation of devices and medications, controls on the import of materials, and so many other areas the federal government controls.

## **Decision-Makers**

You likely know that the United States is not, in fact, a democracy. While some state or local governments have varying elements of direct citizen decision-making, nearly all government decisions are made by elected representatives of the populace or individuals appointed by them. When advocating, it is your responsibility to identify the relevant decision-makers and their priorities.

For major legislation, this can be fairly straightforward. At the federal level, legislation needs to pass both chambers of Congress and be signed by the president. Since the members of Congress are elected, they are often quite willing, if not eager, to talk to local experts. While elected officials ultimately decide how they will vote on legislation or what legislation they will sponsor, many of the details are decided by staff. Many physicians have found that simply by emailing their Congressional office and asking to speak with a staff member about an issue, they are able to talk directly with the individual who is leading

the efforts on a piece of legislation. At the state and local level, elected officials may or may not employ support staff depending upon resources, but the same principle applies. In the next chapter, you can learn more about how to craft that message, but even the best message is lost if you have not reached the right decision-maker.

Congressional staffing in both the House of Representatives and the Senate comes in two forms: personal staff and committee staff. Personal staff work directly for a single member of Congress either in their Washington, D.C., office or their office in their home district. Some staff in both offices will be dedicated to constituent services like arranging tours of the White House or troubleshooting federal benefits applications. Those staff may be quickest to respond to emails but often have little role in developing legislation. For that, you want to speak with the legislative staff, generally based in Washington, though many spend time in the district office. The legislative team generally has titles like legislative assistant, legislative correspondent, or legislative counsel and are led by a legislative director or assistant chief of staff. These staff have areas of responsibility which correspond to the member of Congress' committee assignments or areas of interest. This model allows for legislative staff to develop expertise in their area of focus, although junior legislative staff turnover quickly with an average tenure of only a little over a year and a half.<sup>2</sup> This short tenure and often broad topic area means staff are often eager to learn from field experts from their members' district. For serious advocates with long term advocacy goals, forming relationships with these staffers can prove very helpful, particularly as they become more senior staffers or move to committee work.

Committee staff focus exclusively on the jurisdiction of their respective committee. Legislation must be sponsored by one or more members of Congress, but significant amendments can—and often do—happen in committee. Committee staff are tasked with writing committee reports, identifying experts to provide testimony before the committee, and working with personal staff to further a member's legislative goals. With a few exceptions, committee staff are partisan with parallel majority and minority party staff for each committee. While the average tenure of junior committee staff is still short, under three years, staff are often far more specialized than in personal offices.<sup>3</sup> With specific areas of jurisdiction, committee staff may have executive branch contacts interested in collaborating on legislation or advising on the status of implementation.

We would be remiss if we did not mention political parties. While parties are good indicators of where an elected official stands on an issue and a key source of funding and support for them, resist the urge to only speak to officials from the same party as you. If your elected official is from the other party, it may be particularly important for you to ensure your perspective is heard. Even elected officials with significant party leadership roles such as a majority or minority leader in the House or Senate are unlikely to be interested in your thoughts

unless you are one of their constituents. Even though both major parties publish official party platforms, even a cursory reading of these platform demonstrates they are guidelines and not often specific on issues that may be of interest to you as an advocate.<sup>4</sup>

It is well worth the time to figure out who the key decision-makers are and build relationships with them.

## **Legislative Process**

Otto von Bismark is often credited with the famous phrase “laws are like sausages; it is better not to see them being made.”<sup>5</sup> While sausage making is beyond the scope of this chapter, law making can certainly be messy.

Much of that mess occurs before a law is even proposed. Formally, any member of Congress can write and propose legislation, with their staff generally doing the writing. Informally, a messy game of political wrangling often decides what legislation will be put forth, who will put it forward, and what will make it on the agenda to be considered. In reality, being in the majority party, seniority in that party, committee assignment and leadership position, and national stature matter significantly in determining if proposed legislation will be given real consideration.

Once written and proposed by a member of Congress, other members may “co-sponsor” the legislation. That is to say they attach their name as a public sign of support. It is reasonable to assume a member co-sponsoring legislation will vote in favor of that legislation and more co-sponsors can suggest a piece of legislation is gaining momentum. Bipartisan co-sponsorship is often necessary to achieve the momentum necessary for passage.

Once proposed, a bill is assigned to a committee in the chamber originally proposed. Coordinated bills can be presented simultaneously in the House and Senate and deliberated by committees on both sides of Capitol Hill. Once in committee, it is largely at the discretion of committee leadership, in consultation with party leadership, when and if that bill is discussed and voted upon. If not brought for a vote by the end of the two-year congressional session, the bill “dies” in committee (note: Congressional sessions are numbered. For example, the 118th Congress will meet from January 2023 to January 2025).

Alternatively, a bill that is timely or politically advantageous can be fast tracked for hearings. Hearings are a chance for members of Congress to hear from experts. While at times devolving into political showmanship, testimony before Congress can be impactful to the legislative process and can even influence the national conversation.

If passed in committee, a bill is brought to a vote before the full House or Senate after passing through the rules committee, a political gatekeeper of bills run

by the majority party. Assuming passage, a bill must be approved by the other chamber before being sent to the president to sign into law or veto. In the event of a veto, the bill can be voted upon again in Congress where a two-thirds majority in both chambers can override the president's veto.

The final bill signed into law can differ significantly from the original proposal. Amendments can be proposed in both committees or the full chamber, though party leaders may discourage amendments. If the two chambers pass a bill which is similar or if a bill is amended in one chamber but not another, a temporary conference committee including representatives of both chambers and generally both parties is appointed to work out the differences and propose a final version for a vote in both chambers.

## Moving Forward

The work of elected officials at the federal, state, and local level matters. Many organizations rally their members to write to or call their elected representatives, and the impact of that contact cannot be denied. Particularly at the local and state level, a single call or letter can make a real difference in the passage of a bill.<sup>6</sup> When advocating at the federal level, coalition building makes it possible to have like-minded citizens from around the country contacting their elected officials. Many offices will not read messages from or accept meetings with members of the public who are not in their constituency, so having teammates with broad geographic backgrounds amplifies your effort. That geographic need leads us to our final thought: elected officials serve the interests of those who elect them, so often, before you can convince elected officials, you need to convince the people they represent.

## TAKEAWAYS

- Finding the right decision-maker(s) is important to engaging in meaningful advocacy.
- Legislative staff, particularly specialized staff, are often happy to meet with physician advocates to discuss a specific issue or piece of legislation.
- It is important to contact the offices of elected officials who represent where you live; meaning issues with members across the nation can reach more elected officials.
- The pathway from a bill to a law can be tortuous and will vary federally, state-by-state, and issue-by-issue.





# BUILDING THE WINNING MESSAGE

Christopher Kuhner, MD

**Effective advocacy is contingent upon being able to communicate well.** Framing a clear straightforward message is important in being able to get your point across.

## Why It Matters to EM and ME

Emergency physicians are the champions for our patients – both inside and outside the ED.

But to be effective, we must be able to form clear messages that are simple and persuasive. This will serve us well when it comes to the interests of our patients, our peers, and our own careers.

## How We Got to This Point

Advocacy is at the core of emergency medicine as a specialty as early EM physicians had to advocate for the creation of the specialty. It was not until the right message reached the right people at the right time that years of effort paid off and the American Board of Medical Specialties established emergency medicine as the 23rd specialty.<sup>1</sup> Persistent, effective messaging has been baked into the fabric of EM ever since, from clear and focused patient presentations to advocacy efforts that led to the creation of EMTALA.<sup>2,3</sup> In fact, it is so important it was written into our professional obligations. According to the ACEP Code of Ethics for Emergency Physicians, emergency physicians have an ethical duty to promote population health through advocacy and to participate in “efforts to educate others about the potential of well-designed laws, programs, and policies to improve the overall health and safety of the public.”<sup>4</sup>

## Current State of the Issue

It is our duty to stand up for our patients, our specialty, and ourselves. But persuasive communication is no mean feat in the 21st century, when the average attention span is less than 1 minute.<sup>5</sup> Let’s think of the winning message as the perfect combination of who, what, when, where, and why.

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*What does a winning message include? Sometimes it’s human-interest stories, sometimes it’s data. Come with both.*

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## Who

A key element of effective messaging is getting in front of the right audience. Make sure you know who represents you – and what committees they serve on. It is also important to ensure that they have jurisdiction over the issue; meaning if it is a state level issue, do not ask your congressional representative at the federal level to help solve the problem. While working with the member is often an early advocates goal, the legislative staff members are powerful advocates (think of them as the office’s program coordinators) and can be the thought leader in the office on a particular subject. Lawmakers want to hear from their constituents and from subject-matter experts, but their time is limited. You will almost always start by speaking with the staff who want to hear from you. You can find them easily:

- Federal offices (both Senate and House): <https://www.congress.gov/>
- State legislative sites: <https://www.congress.gov/state-legislature-websites>

While it’s important to speak to the right people, it is also important to understand that the same message delivered by different people can have a different effect. As a physician, your voice carries weight. A survey of legislative assistants reported that 90% of physician lobbyists were either very effective or somewhat effective — and, in the words of one legislative assistant, “should recognize the power they have to influence Congress.”<sup>6</sup> Moreover, within the current health care system, emergency physicians provide a disproportionate share of the care for the underinsured and can speak to their challenges far more than other specialties.<sup>7</sup>

Partnering with supportive organizations such as EMRA, ACEP, AMA, or a local grassroots network can add the legitimacy of a trusted source and weight of popular opinion to your issue. The more front and center an issue, the more likely legislators are to respond and act. Additionally, these professional organizations may have already laid the groundwork to present your issue. Their government affairs staff may have established relationships with legislators and can help refine and tailor your arguments.<sup>8</sup> They can offer contacts to like-minded interest groups and lobbyists. Inviting stakeholder groups to participate in your effort can earn valuable allies, bolster support, and facilitate passage of a bill. Just as modern medical paradigms incorporate a health care team with a physician as team leader, various members of a lobbying team bring diverse knowledge and skills to the table, resulting in more effective advocacy.<sup>9</sup>

## What

What does a winning message include? Sometimes it’s human-interest stories, sometimes it’s data. Come with both. A renowned example of this occurred during the debate about patient dumping, before EMTALA became law. After plentiful data had been submitted and discussed, Dr. Arthur Kellermann dumped

hundreds of patient wristbands onto a table to visually illustrate the human toll of patient dumping — creating a pivotal point in the debate.<sup>2,3</sup> Emergency physicians may be governed by data, but politics is often governed by the human story and personal impact. **Do not hesitate to get personal and share the challenges you see on your shift on an issue; it is the stories they will retell in a speech, not the data.**

## When

Effective messaging is rarely a one-and-done endeavor. Marketers adhere to the “Rule of 7,” which holds that an audience needs to be exposed to a message seven times before they’ll take action.<sup>10</sup> Digital media — from websites to automated messaging to social channels — makes it at once infinitely easier to reach people and infinitely more difficult to make your message stand out in the noise. But macro messaging is not enough. Make it personal. Establish direct contact with your elected officials. Reach out to staff who are responsible for the daily office activities. Utilize local, state, and federal websites to get names and contact information. Then keep in touch when legislators hold town halls, seek constituent feedback, and when policy concerns arise.

Notably, ACEP holds a Leadership and Advocacy Conference every spring, designed to help you learn how to craft a winning message, not only for federal issues but also at the local and state levels. The conference also allows participants to network with others interested in advocacy and go to the hill to practice delivering their message.

## Where

Another key component of a winning message may surprise you: location. A randomized trial conducted by a lobbying firm found that state lawmakers who were socially lobbied — approached outside of a formal office setting — were more likely to be supportive, and a subsequent survey of registered lobbyists found social lobbying to be a common occurrence. *“Political elites are influenced by the social environment; interest group direct lobbying is influential when conducted in places not easily observed by the public.”<sup>11</sup>*

## Why

As physicians, we are taught to focus on objective data to make decisions. However, scientific evidence alone is not enough for effective messaging. You must tell people why they should care about an issue. Tragically — as seen during the COVID-19 pandemic — “for the greater good” is no longer a convincing reason for a significant segment of the population to care. Bring them more. Make it personal.

The policy world is complex, and scientific evidence is unlikely to be conclusive in making decisions. Timely qualitative, interdisciplinary, and mixed-methods

research may be valuable in advocacy efforts. The potential impact of evidence can be increased by “packaging” it as part of knowledge transfer and translation. Increased contact between researchers and policymakers could improve the uptake of research in policy processes. Researchers can play a role in advocacy efforts, although health professionals and disadvantaged people, who have direct contact with or experience of hardship, can be particularly persuasive in advocacy efforts.

Different types of advocacy messages can accompany evidence, but messages should be tailored to the target of the advocacy. Several barriers hamper advocacy efforts. The most frequently cited in the academic literature are the current political and economic zeitgeist and related public opinion, which tend to blame disadvantaged people for their ill health, even though biomedical approaches to health and political short-termism also act as barriers. These barriers could be tackled through long-term actions to raise public awareness and understanding of the SDH and through training of health professionals in advocacy. Advocates need to take advantage of “windows of opportunity,” which open and close quickly, and demonstrate expertise and credibility.

## Moving Forward

Effective messaging will be important at every phase of your career, whether you’re advocating for your patients or for yourself. Knowing the key decision-makers, being familiar with the legislative process, and becoming effective in communicating with the parties who influence that process will make you a success.

### WHAT’S THE ASK?

- The winning message is a combination of who you approach, when, where, and why.
- Be ready to repeat your message multiple times, in multiple ways.
- Join forces with your colleagues in organized medicine for a more impactful presence.
- Establish and maintain regular contact with your representatives and their staffs.



# THE FOURTH BRANCH OF GOVERNMENT: REGULATORY ISSUES

Melanie Yates, MD; Rebecca Leff, MD; Chadd K. Kraus, DO, DrPH, CPE, FACEP

**Physician advocacy is often focused on elected officials.** However, emergency physicians can engage in effective advocacy targeting the regulatory process, including federal regulatory agencies, the so-called “Fourth Branch of Government.”

Regulatory agencies are the governmental entities that administer the laws passed by the legislature. These bureaucracies clarify, interpret, and enforce how legislative mandates will be implemented in practice.

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*After a bill becomes law, a regulatory agency first interprets the law itself, and then sets up rules for how it will enforce its interpretation of the law..*

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## Why It Matters to EM and ME

Policies impacting the practice of emergency medicine are determined at both the legislative and regulatory level, making regulatory advocacy an important tool to impact change. Regulatory agencies administer the laws passed by the legislature, including agencies you may be familiar with such as the Center for Medicare and Medicaid Services (CMS) and the U.S. Food and Drug Administration (FDA). When Congress enacts legislation directing an agency to perform a task, the agency may then issue regulations that further interpret the language used in the original legislative text. In other words, regulations are laws “in action,” issued to practically carry out the intent of enacted legislation in everyday life. The regulatory rules, process, and details often far exceed the volume and detail of the underlying enabling legislation.

Consider, for example, that laws applying to emergency departments rely on how regulatory agencies define the term “emergency department.” After EMTALA was passed, the Department of Health and Human Services defined an “emergency department” to include hospital-affiliated EDs, but not independent, freestanding EDs. This means that EMTALA regulations do not apply to many independent freestanding EDs, as they do not qualify as emergency departments under the regulatory agency’s definition of the term.

The implications of this definition mean that EM physicians bill for emergency care only at hospital-affiliated EDs, while at independent freestanding EDs, care can only be billed to Medicare as a general office visit. The EMTALA legislation further dictates that EMTALA obligations are triggered when a person “comes to” an emergency department. But it is the role of the regulatory agency to define if this term applies to the moment a person walks through the door, reaches the sidewalk in front of the ED, enters a hospital-owned ambulance, or parks their car in a hospital parking lot. In fact, federal regulations clarify that a person is considered to have “come to” the ED just by standing on a hospital’s parking lot or adjacent sidewalk even if they have not physically entered an ED.

Given the significance of the regulatory process, regulatory agencies such as CMS are not conventionally staffed by actively practicing health care providers. Thus, regulators may define terms or address issues in a manner that is inappropriate or adverse to the practice of emergency medicine. They may use language that is inaccurate, problematic, or not commonly accepted by emergency medicine clinicians.

Agencies generally can issue, modify, or amend regulations without seeking additional approval from Congress. One example of this was a June 2013 memorandum from CMS that clarified the regulations for physician coverage requirements. Under the Conditions of Participation for critical access hospitals and EMTALA, this availability coverage could be fulfilled when non-physician providers at critical access hospital EDs are equipped with ED-based telemedicine. This is different from the previously accepted understanding, which required a physician to be onsite to respond in person to emergencies, even in such cases where an ED is staffed by a qualified NPP. In practice, this means that substantial alterations can be made between the time a bill is signed into law and the time that rules for implementation are written and enforced at agency discretion.

Therefore, the changes that take place as part of the regulatory process can reverse significant legislative achievements by clinicians if agencies put into practice an adverse interpretation or administration of a new or existing law. Alternatively, working with these same agencies can sometimes palliate a legislative loss. Regulatory advocacy can be as important, or even more important, than the initial legislative advocacy to get a proper resolution.

**Figure 21.1. Quick Guide to Regulatory Advocacy**



## How We Got to This Point

From a historical standpoint, the first nationally recognized law that allowed for regulations was enacted in 1887, known as the Interstate Commerce Act.<sup>1</sup> This allowed for the first regulatory commission to limit railroad rates. Throughout the 20th century, there were further expansions of regulatory bodies by Congress and the executive branch. In 1946, the Administrative Procedure Act was passed, which was likely the first regulatory reform bill and governed the way by which federal agencies develop and issue regulations.<sup>2,3</sup> This has led to the formation of departments and agencies that are in charge of creating and implementing regulations based on instituted laws, such as the Department of Health and Human Services, which houses the Centers for Medicare and Medicaid Services (CMS), the Centers for Disease Control and Prevent (CDC), the Food and Drug Administration (FDA), and the National Institutes of Health (NIH). This process is similar at the state level, but it may vary based on each state's constitution and administrative procedures.

After a bill becomes law, a regulatory agency first interprets the law itself, and then sets up rules for how it will enforce its interpretation of the law. During this pre-rule period an agency may gather more information before issuing a mandatory notice of proposed rulemaking. From there, these preliminary rules must be made available to the public via the Federal Register for comment. This comment and question period, which is 30 days on the federal level and may vary by state, is a key window during which citizens, physicians, and organizations can advocate for specific changes to the rules prior to full implementation. Public hearings may also be conducted at this time and serve as an additional opportunity for advocates to articulate their position on an issue. The Final Rule published must recognize all substantive comments received during the comment period, as well as explain how the agency addressed them. The Final Rule is promulgated in the Federal Register and includes an effective date, which is generally no sooner than 30 days after rule publication. Once a final rule is issued, the comment period for that rule has ended, and advocates will need to consider other strategies to address any concerns with a given rule.

For an example of this process in action at the federal level, the “No Surprises Act” was signed into law on Dec. 27, 2020. Initial regulations were drafted by multiple regulatory bodies, including the Personal Management Office, IRS, Employee Benefits Security Administration, and the HHS Department. These initial regulations were then made available for public comments, and an interim rule was issued to restrict surprise billing for patients seeking emergency and non-emergency care from out-of-network providers at in-network facilities on July 1, 2021. There are currently two rules still available for public comment, the second interim final rule for establishing the dispute process for payments, and the third interim final rule for the submission of information on prescription drug prices and health care spending. While the law was passed at the end of 2020,

the actual implementation of the “No Surprises Act” is still being determined at the regulatory level.<sup>4</sup>

Health services research can be a key factor in the influence of rules and regulatory changes. Research into legislation and then the following implementation of the law may be able to identify possible harms and benefits of policy and its rules, estimate costs for private and government sectors, and better define the problem that a rule can help fix.<sup>5</sup> This type of research has assisted in forming legislation and regulations that improve the process for addressing medical errors, implementation of value-based care into the Affordable Care Act, and mental health parity.<sup>5</sup> Active health services research is constantly needed and sought after to help advocate for evidence-based regulations and rules from multiple state and federal organizations like ACEP or from government agencies, such as the HHS, CMS, or CDC.

## **Current State of the Issue**

There are two important opportunities for advocacy to influence proposed regulations: the pre-rule stage and public commentary stage, including public hearings. During the pre-rule stage, agencies formulate a draft rule based on the administrative agenda and wording of legislation. This means any pre-rule comments and questions from organizations and individuals will be extremely beneficial in creating the regulation. During the public comment period, organizations and private citizens can advocate via public hearings and online comment forums to influence the wording of the final rule.

ACEP and EMRA, along with many other health care organizations, keep track of multiple rules that have the power to affect health care providers and patients. From here, these organizations will reach out to their members to ascertain a consensus on the rules being proposed, and what changes members might like to see. The organizations will then submit informed member and stakeholder feedback. In addition, individuals can submit informed comments about specific rule proposals via [www.regulations.gov](http://www.regulations.gov).

## **Moving Forward**

There are multiple important current issues to keep an eye on over the next year, including COVID-19 regulations, the No Surprise Act and its regulations, Medicare payments and policies such as telehealth, violence in the ED, and medical management of opioid use disorder. ACEP monitors and reports on federal regulatory issues that will affect the specialty, through its Regs & Eggs newsletter for members.<sup>6</sup>

As private citizens, we have the ability to comment on proposed regulations. As emergency physicians, we have a unique perspective on how suggested regulations can affect our patients, our practice, and our future as a specialty.

Every citizen has easy access to comment on these possible rules. In addition, ACEP and EMRA will often elicit feedback from members for thoughts on specific regulations to form a consensus opinion that will be used to propose changes to the preliminary rules presented by the regulatory agencies. There will always be new laws and rules that will require our advocacy in order to protect our patients and practice.

## TAKEAWAYS

- For federal and state laws to be implemented, rules must be created, reviewed and revised, and then finalized by regulatory agencies.
- Regulatory advocacy can be as important as your original legislative advocacy to make effective change.
- There is a public comment period for all rules, and it's important for physicians and organizations to weigh in.
- Keep up to date on when to advocate for regulatory changes during the allotted commentary time frame.
- Get involved with health services research. It helps organizations and agencies advocate for better informed policies and regulations.



# THE FIGHT NEVER ENDS:

## JUDICIAL CHALLENGES

Jacqueline Buchak, MD; Colten J. Philpott, MD, MPH, MBA, MHA, MPA;  
Heidi Knowles, MS, MD, FACEP

**The United States is governed by two distinct legal systems: state and federal.** Once legislation is passed through the legislative branch, signed into law by the executive branch, and enacted by the regulatory agencies, it is still at risk of being changed when contested through the legal systems. It is because of this that we must stay vigilant for any changes that may affect our specialty and our patients.

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*While advocacy is often focused on the legislative process, judicial actions can be an important tool in the armamentarium of an effective advocate.*

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### Why It Matters to EM and ME

While advocacy is often focused on the legislative process, judicial actions can be an important tool in the armamentarium of an effective advocate. In Washington State, legislators attempted to limit Medicaid reimbursement to three emergency department visits per year for “non-emergent” visits. A non-emergent visit was defined by regulators in that case to include chest pain, abdominal pain, seizures, or miscarriage among a list of 700 codes. Emergency physicians through ACEP were able to respond to this proposition and stopped these limitations from passing through legal action after they were unable to stop it at the legislative and regulatory level.<sup>1</sup> If the physicians there had given up without involving the courts, emergency medicine might be quite different today.

### How We Got Here

The courts, both state and federal, are governed by their enabling documents, generally the state or federal constitution and relevant laws passed to regulate their administration. These courts are largely defined by jurisdiction, or the types of cases they are authorized to review. State courts hear cases that involve state laws and are not directly against the United States, as well as cases involving certain specific federal laws (eg, antitrust, patent, copyright). Most criminal cases

are heard in state courts, as they typically are violations of local or state law. Federal courts, having limited jurisdiction, only hear cases involving laws passed by Congress and the U.S. Constitution, as well as cases that arise between citizens of different states.

## **The State Court System**

The state court system is organized as a hierarchy, including trial courts and a state supreme court. Trial, appellate, and state supreme court judges are typically elected at the county and municipal levels or appointed by the governor. Superior courts review both criminal (violent and nonviolent) and civil cases, providing the first opportunity for legal review of a concern. For purposes of emergency medicine advocacy, most issues will be of a civil nature as criminal matters are at the discretion of the state charging entity, not the individual.

In civil litigation, either side who loses at trial may appeal to the state appellate courts. These appeals are argued before a panel of judges rather than a jury. These judges reach a decision by majority vote, allowing the original court decision to stand, be reversed, or they can call for a new trial altogether. Appellate decisions can be appealed to the state supreme court, the state's last level of appeal. It is important to note that at any level of the appellate process, the judges are evaluating for inappropriate application of the law, not hearing the case *de novo*.

## **The Federal Court System**

Federal cases start in a U.S. District court, the trial court of the federal court system. Each state has one or more federal districts, depending on population. These cases can be appealed at one of the 13 Circuit Courts, the first level of appeal. The final level of appeal is the United States Supreme Court in Washington, D.C., which oversees all federal courts. The U.S. Supreme Court consists of eight associate justices and one chief justice, for a total of nine justices. Federal judges are all nominated by the U.S. president and confirmed by the Senate, and they preside for life unless impeached or voluntarily retire.

Many issues on the federal level are of interest to emergency physicians, the most recent of which include the impacts of COVID-19 mandates, laws regarding surprise billing, and the 2022 overturning of the *Roe v. Wade* decision.

## Current State of the Issue

A prime example of the effects on regulatory efforts of the judicial process is the onslaught of challenges against the CDC mandates during the COVID-19 pandemic. Orders for the mandatory use of face masks on public transportation, under the Regulations to Control Communicable Disease,<sup>2</sup> were challenged in many states, as some consider this a violation of rights. A federal judge in Florida overturned the rule, and the CDC appealed. Ultimately, the power of the CDC to lead mitigation efforts in future pandemics will be determined by this decision.

Legislation, even when newly passed, can be challenged throughout the initial implementation process. The 2020 No Surprises Act (NSA), which took effect Jan. 1, 2022, created federal protections to shield patients from balance billing for out-of-network emergency care or scheduled out-of-network services at in-network facilities, and it prohibited higher deductibles for out-of-network care than for in-network care (without patient notification and consent). This Act had bipartisan support when passed by Congress, but it was then challenged in court. To date, multiple organizations, including ACEP, the American Medical Association, the American Society of Anesthesiologists, and the American College of Radiology have all filed lawsuits contesting the No Surprises Act. Importantly, the Texas Medical Association (TMA) and Emergency physician, Dr. Adam Corley, are the plaintiffs in one of these suits.<sup>3</sup> The initial ruling, in the U.S. District Court for the Eastern District of Texas, ruled in favor of the TMA, effectively invalidating part of the bill the IDR process nationwide. Shortly after, CMS and the Department of Labor (DOL) issued a statement that they were revising their rules the IDR based on the Texas court ruling. While the litigation was ongoing at the time of this publication, addressing the issues raised by the plaintiffs could help make the appeal moot before it is heard.

Even when a law is considered settled, the relevant supreme court at the state or federal law can change precedent. In an impactful recent change of law, the federal Supreme Court overturned the *Roe v. Wade* decision, altering access to health care for millions of Americans. *Roe v. Wade* was an historic decision made in 1973, ruling that the U.S. Constitution protects a woman's choice to have an abortion,<sup>4</sup> and it ultimately invalidated many state and federal laws regarding abortion. In 2018, the *Dobbs v. Jackson Women's Health Organization* case challenged Mississippi's 2018 Gestation Age Act, a law that had banned abortions after 15 weeks (exceptions were made for fetal abnormalities and medical emergencies). The Jackson Women's Health organization sued, and the federal courts stated this law contradicted a previously established 24-week age of viability. The state of Mississippi subsequently asked the Supreme Court to hear the case. The Court agreed, limiting it to one question: "whether all pre-viability prohibitions on elective abortions are unconstitutional."<sup>5</sup> On June 24, 2022, the U.S. Supreme court issued a 5-4 decision to overturn the *Roe v. Wade* ruling, returning the decision regarding abortion to the states.

## Moving Forward

We must continue to be vigilant in monitoring legislation that will affect EM and our patients, not just in the lawmaking process, but in the subsequent years as laws are challenged in court. As an individual, you can start by establishing relationships with your representatives at the local, state, and federal level. These relationships are key to ensuring that laws passed and rules made are beneficial, both for our patients and our specialty.

Maintaining membership in specialty organization that represent you is another important way to contribute to this process, as these organizations rely on member support to monitor for threats / changes and to advocate, including through legal challenge, on behalf of you and the patients you serve.

### TAKEAWAYS

- Advocacy does not end once a bill is passed and becomes law.
- Legal challenges can have a significant effect on how laws are interpreted and enforced.
- How laws are interpreted and enforced can affect every level of the health care system, from patients and clinicians to insurers and health care systems.
- We must be vigilant in monitoring for these threats, advocating for our patients and our specialty when needed.



# ADVOCACY FOR EVERYONE

Laura Haselden, MD, MPM; Hannah Thielmeyer, MD; Brittany CH Koy, MD

**Doctors often vote and participate in community service less frequently than other similarly educated professionals – as workers in a helping industry, it’s easy to feel as though our clinical work fulfills our need to serve our communities.<sup>1</sup>**

However, we operate within an incredibly complex health care system in which, perhaps, no specialty sees the challenges of health care more clearly than the emergency physician. In our position at the intersection of all fields of medicine and society, we have a responsibility to ensure that policies that affect us, our patients, and the practice of medicine are informed by evidence and are made with consideration of the needs of everyone.

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*Where legislation attempts to dictate physicians’ ability to deliver care or promote public health, our responsibilities go beyond the bedside and into the sphere of advocacy.*

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None of us can engage in direct action, or even invest our emotional energy, in every issue relevant to the health of our patients or our practices. However, the breadth of factors that shape our practice virtually guarantees that an issue exists that’s interesting and accessible to each of us. Advocacy is for everyone; regardless of your politics, interests, subspecialty, or even your bandwidth at any given time, there’s a way you can participate.

## Why It Matters to EM and ME

We have all experienced failures of the health care system that have impeded patient care and made our jobs harder. Advocacy gives us an opportunity to address these systemic challenges by using our frontline experience to promote solutions that meet the needs and address the shortcomings of the system.

## How We Got Here

A seemingly fundamental part of the human experience is trying to influence the actions of others. The American political arena takes this to a new level, with groups trying to exert control over any number of issues for a wide range

of reasons – not all of which align with the ethics of physicians. The advocacy work that we must do can be broadly grouped as physician self-advocacy, health and health care advocacy, and advocacy for the broader social determinants of health. This chapter will explore a selection of topics in each.

## **Current State of the Issue**

### **Physician Self-Advocacy**

#### **Mental Health**

Physician mental health stands out as one of the landmark issues in physician self-advocacy over the past several years. Approximately 40% of emergency physicians are estimated to experience high levels of burnout and emotional exhaustion,<sup>2</sup> and the rate of physician suicide remains high, although it has declined since the 1980s.<sup>3</sup> In response to these rates and the increased stressors of the COVID-19 pandemic, professional organizations, including ACEP, joined forces to facilitate the passage of the Dr. Lorna Breen Health Care Provider Protection Act, in memory of Dr. Lorna Breen.<sup>4</sup> This federal law provides grants to promote mental health and access to mental health care for health care workers, and it funds research and development of best practices to prevent suicide among health care workers, lower the barriers to care and treatment, and promote strategies for resilience.<sup>4</sup>

The passage of this bill represents a success story of combined lobbying and legislative efforts of a broad coalition of health professional organizations. As we have recognized the stressors and demands of our careers, we have leveraged our combined political power to push for federal support for our needs.

#### **Equitable Pay**

Other ongoing issues in physician self-advocacy include the push for pay parity. Doximity reports that emergency medicine has the fifth smallest gender pay gap among medical specialties; however, salaries for male and female physicians remain inequitable, with the average annual salary for men estimated at \$360K, but for women at \$315K.<sup>5</sup> This pay inequity can total nearly \$2 million over the course of a career.<sup>6</sup> Pay disparity is complicated by the burdens of child care falling disproportionately on female physicians, which exacerbates wage disparity and increases burdens of mental and emotional stress.<sup>7</sup> Advocating for pay transparency and equity among individual health care systems, throughout contract management groups, across geographical regions, and nationally will help keep emergency medicine in the top specialties for pay equity.

## Parental Leave

Similarly, inconsistent policies surrounding parental leave and parental return-to-work support create both financial and emotional burdens on physicians, particularly in the residency setting. Parental leave often requires residents to use vacation time, elective time, short-term disability, or unpaid leave through the Family and Medical Leave Act (FMLA).<sup>8</sup> The American Board of Medical Societies requires specialty boards to allow for a minimum of 6 weeks of family or parental leave at least once during residency without extending training or using up all other time away; however, their policy allows for averaging and accrual of vacation time and does not make any recommendations about paid versus unpaid leave.<sup>9</sup>

Using vacation or elective education time to give birth or adopt a child adds to the stress on new parents and is a disservice to the education of residents, who fundamentally participate in residency programs as an educational endeavor.<sup>10</sup> Beyond unclear leave policies surrounding the birth or adoption of a child, many programs and hospitals also do not have a straightforward policy for return to work or support services such as lactation rooms, accessible child care, or flexible coverage policies.<sup>11</sup> These systemic failures create barriers to autonomous reproductive decisions and disenfranchise birthing parents from the workforce.

Within emergency medicine, EMRA advocates for a clear, straightforward parental leave policy that emphasizes equitable access to paid leave for both birthing and non-birthing parents, separate from vacation time, with flexibility in accrual of leave time, and with minimal extension of training periods. The American Board of Emergency Medicine (ABEM) developed a parental leave policy that allows for residents to take up to 8 weeks of family leave per year without extending training, from a previous maximum of 6 weeks annually.<sup>12</sup> Sustainable and financially supported parental leave may serve to narrow the pay gap and reduce the exodus of parents from the workforce. In our efforts to facilitate the success of physician parents, we should advocate to our governing bodies, and to our individual employers, to work holistically to expand parental and familial leave to the maximal extent possible within the bounds of our accrediting bodies. Parental and familial leave should be offered liberally to both birthing and non-birthing parents without pressure or stigma. Supportive policies upon return to work will help ensure the continued success of parents in the workforce.

To facilitate the cultural shift necessary to destigmatize parental leave policies, programs should begin openly discussing parental leave policies with all prospective residents. A comprehensive and generous leave policy serves as an effective recruiting tool; the precedent set by prioritizing family wellness from recruitment forward will shape the culture of the residency.<sup>13</sup> Outside of our own

residencies and colleges, we should advocate for national, paid parental leave policies - medicine is certainly not an outlier in perpetuating inadequate parental leave policies. We broadly recognize the benefits of adequate parental leave on the health and wellbeing of both parent and child<sup>14</sup> - we must advocate for these benefits for both ourselves, and our society.

## **Health and Health Care Delivery**

Beyond advocating for ourselves and our careers directly, countless opportunities exist to advocate for our patients and the practice of medicine. The health care system has faced legislative threats to the autonomy of care delivery and patient-physician privacy for generations, and evolving political dynamics have exacerbated these threats. From historical restrictions on medication-assisted treatment for opiate use disorder, to ongoing legislative efforts at state and federal levels to restrict abortion access, reproductive health care management, gender-affirming care, and firearm safety - legislation that interferes with our delivery of care has created harm for our patients. Advocacy in these areas is critical and holds the potential for powerful change.

### **Substance Use Disorder Treatment**

Consider the so-called X-waiver. After the initial authorization of buprenorphine under the Drug Addiction and Treatment Act of 2000<sup>15</sup> for medication-assisted treatment for opiate use disorder (MOUD), its use was restricted under the DATA waiver, or X-waiver.<sup>16</sup> This restriction was codified in federal law, which then created systemic barriers to initiation of MOUD, requiring doctors to undergo extensive training and additional licensure to prescribe a medication with similar or lower risks to other opiates, at the expense of patients' access to this care.<sup>17</sup> Physicians from a wide range of specialties decried these regulations and spent years advocating for the removal of the X-waiver in order to improve patient care. Section 1262 of the Consolidated Appropriations Act of 2023 (also known as Omnibus bill) effectively ended the X-waiver, signifying an important victory for health care advocates.

### **Reproductive Health Care**

Similarly, while the provision of elective abortions is generally not within EM's scope of practice, proposed abortion bans and criminalization have implications for both us and our patients. Our charts carry legal significance, particularly in states that have prepared legislation to criminalize patients and clinicians suspected of undergoing or performing abortions. We, as physicians, recognize "abortion" as the appropriate medical diagnosis for both spontaneously-occurring and induced termination of pregnancy; however, legislation constructed without medical expertise has created environments in which our medical diagnoses pose legal threats to both our patients and colleagues. Abortion bans have also historically resulted in increased morbidity and

mortality to our patients.<sup>18,19</sup> Regardless of one's personal opinions surrounding elective abortions, blanket criminalization of medical care that saves lives is unacceptable. Our responsibility to our patients requires that we demand the unrestricted delivery of care, dictated by evidence-based principles and our ethical requirements to our patients and unencumbered by political, personal, or religious agendas.

Moreover, the precedent set when non-medical legislators and politicians dictate medical care without knowledge of the medical evidence behind these policies threatens the integrity of health care delivery. We have already seen this pattern extending into legislative efforts to criminalize gender-confirming health care in states like Texas.<sup>20</sup> These legislative efforts to restrict care that is personal, evidence-based, and lifesaving are tantamount to the practice of medical care without a medical license and are entirely in opposition to medical standards of best practice. Our responsibility as physicians is to defend the evidence-based practice of medicine. Where legislative barriers seek to prevent this, our responsibility to our patients and our profession is to take direct action against the restrictions imposed against us — advocacy is our lane.

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*Historically disenfranchised populations experience increased rates of gun violence, air pollution and heat trapping (with related health outcomes), higher maternal morbidity and mortality rates, and increased police brutality.*

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## Firearm Safety

For years, physicians have butted heads with the NRA and similar groups about the role of medicine in advocating for gun control. Over the past several decades, physician gag laws have been crafted to prohibit physicians from talking to patients about firearms and firearm safety, despite medical boards recommending these conversations as best practice.<sup>21</sup> These gag orders have been deemed unconstitutional, as they violate physicians' First Amendment rights; however, attempts to restrict physician's ability to discuss issues deemed political or controversial persist.<sup>22</sup> Physicians also remain poor at asking about, and counseling on, firearms and firearm safety.<sup>23</sup> This failure is partly due to misinformation about the physician's right to legally discuss firearms - while some states have laws that say physicians cannot be specifically required to ask about firearms, in all states, if physicians have good-faith concerns that firearms affect a patient's medical care or risk, they are allowed to ask and counsel on firearms and safety. For patients at high risk of suicide or interpersonal violence, we are, and must remain, able to discuss safety measures.

## Other Public Health Issues

Beyond the right and responsibility to counsel individual patients on their respective risk of harm from firearms, physicians have a responsibility to advocate for public health measures that promote the wellbeing of our communities. Physicians have long been involved in matters of public health - seatbelts, tobacco, leaded gasoline, to name a few. This involvement is more than a hobby; it is an ethical obligation. We are bound by our oaths to promote and preserve health and wellbeing when it is within our knowledge and ability to do so. We face frequent legislative interference in public health efforts, driven by financial and politically motivated interests. For example, oil companies have lobbied for legislative restrictions on physician disclosure of the risks of fracking in states where fracking poses a major source of oil revenue.<sup>24</sup> Where organizations and industries leverage their power to influence health care out of financial or political motivations, it is the responsibility of the house of medicine to advocate for the interest of our patients, in keeping with evidence-based best practices. Where legislation prevents adequate research, as seen in federal prohibitions on funding firearm research imposed by the Dickey Amendment, it is our responsibility to advocate for the acquisition of this evidence.<sup>25</sup> Advocating for the repeal of all legislative barriers to our provision of best care is well within our rights and responsibilities.

In short - it is essential that physicians advocate for our right to practice medicine in keeping with our knowledge, experience, and the responsibilities of our oaths. Where legislation attempts to dictate our ability to deliver care or promote public health - abortion access, gender-affirming care, firearm safety, etc. - our responsibilities go beyond the bedside and into the sphere of advocacy. Forces outside of health care will attempt to restrict our practice; it is the responsibility of each of us to ensure our autonomy and ability to provide effective care.

## Social Determinants of Health

While advocating directly for our practices and against interference into our delivery of care is essential, it is also our responsibility to recognize the factors outside of the direct delivery of health care that influence our patients' health and ability to access health care.

## Access and Affordability

We have all seen the effects of high-cost health care on our patients' ability to access care, leading patients to enter the emergency department late in their disease course and critically ill. We've cared for the patients unable to access regular dialysis; we've made the stage IV cancer diagnoses. We've had parents refuse testing or treatment out of concern for cost. We've cared for patients dying of temperature-related illnesses, from exposure, from malnutrition. We must advocate for both financial and physical access to preventative health care.

The social factors that determine our patients' ability to care for themselves, and to access medical care, often play a far greater role in their overall health and wellbeing than we do. Promoting the health of our patients requires us to recognize this fact, and advocate for social systems and safety nets that allow our patients to meet their needs. Physicians should consider the implications of access to health insurance, preventative care, housing, mental health and substance abuse treatment, employment training, and food security for our patients, and advocate accordingly. We should consider and screen for social determinants of health in the emergency department, maintain awareness of our community and health systems' resources to address these needs, and advocate for the expansion of these services.

### **Racial and Socioeconomic Disparities**

Physicians also carry the responsibility of recognizing and working to narrow health and health care disparities that arise from discrimination both within and without the health care system. Racial and socioeconomic disparities within health care access have only become more pronounced as health care resources have been stretched to their absolute limits during the COVID-19 pandemic.

In particular, medical and systemic racism have been demonstrated to exacerbate nearly every issue described herewith – historically disenfranchised communities experience increased rates of gun violence,<sup>26</sup> more air pollution and heat trapping (causing worse health outcomes),<sup>27,28</sup> higher maternal morbidity and mortality rates (increasing the risk of restriction of abortion access and maternal health care),<sup>29-31</sup> and increased police brutality.<sup>32</sup> If we intend to advocate for progress on these issues, we must acknowledge their intersectionality. This includes recognizing our own cognitive biases and implicit racism and working to unlearn them, in addition to advocating for systemic changes and policy solutions. This should include a culture that directly and immediately corrects harmful behavior and biases, systems that pay appropriately qualified minority educators to assist in formal diversity and equity training, and continuing medical education throughout our careers on the social determinants of health and health disparities. It should also include the recognition of challenges that our minority colleagues face at the hands of a specialty that is still predominantly white, with systemic interventions to make EM more diverse at all levels of practice and leadership.

### **Climate Change**

We must also recognize the implications that our practices have on the health of our environment. American health care is one of the industries that contributes most to carbon emissions and climate change; simultaneously, our patients are dramatically affected by the evolving challenges of a changing climate.<sup>27,28</sup>

Physicians can take a range of actions to help fight climate change, including advocating that hospitals provide a plant-forward menu, selecting medications and dosing strategies with lower carbon footprints, conducting research into the link between climate change and health, and direct lobbying for regulation of supply chains and emission standards.<sup>33</sup>

## Moving Forward

Even outside of our direct delivery of health care, our commitment must remain to public health. The barriers to public health are ever-changing - we continuously witness the evolving threats of infectious disease, police brutality, gun violence and other interpersonal violence, racism and xenophobia, climate change, and substance use disorder. It is functionally impossible to meaningfully engage in direct advocacy on every issue that's relevant to our practices while maintaining our clinical acumen and well-being. However, we must acknowledge that all aspects of our society are interconnected. The challenges faced by our patients are driven by the effects of social policies; awareness of these challenges is the sine qua non for advocating for change.

Organized advocacy groups like ACEP and EMRA provide an excellent place to start — for those less interested in politics, these organizations function as an extensive repository of knowledge and organized lobbying power and are a convenient first step into advocacy. However, organized medicine should be seen as neither necessary nor sufficient – there is an avenue for advocacy for everyone, of any political affiliation or sentiment, at any stage of your career. Our responsibilities are to our patients and our practices. None of us can do everything, but everyone should do something.

## TAKEAWAYS

- Emergency medicine is a frontline specialty uniquely positioned to identify the needs of a diverse population of patients and the shortcomings of the system.
- We can advocate for ourselves, the health care system, and the social determinants of health that affect our patients and communities.
- Self-advocacy includes mental health access, pay equity, and supportive parental leave policies throughout residency and our careers as physicians.
- Health care advocacy should prioritize basing health policies on evidence and best practice rather than political or individual agendas.
- We have the responsibility to advocate for our patients' ability to live healthy lives, which includes acknowledging and combatting social determinants of health.
- The issues facing our careers and our patients encapsulate a broad variety of areas for advocacy, and there is space for every physician to contribute in a way meaningful to themselves and their patients.

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