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December 15, 2022

President Joseph R. Biden
The White House
1600 Pennsylvania Avenue NW
Washington, DC 20500

Mr. President:

The Society of Hospital Medicine (SHM), representing the nation's hospitalists, offers our support for and perspective on the November 7, 2022 letter submitted to you by the American College of Emergency Physicians (ACEP) regarding emergency department (ED) boarding. We are equally concerned about the crisis of patients boarding in the emergency department, and echo the points raised in the ACEP letter.

Hospitalists are front-line physicians in America's acute care hospitals whose professional focus is the general medical care of hospitalized patients. Hospitalists are the primary, or "attending," physicians for most patients admitted to hospitals. While hospitalists have felt the impact of delayed discharges and patient boarding, recent AHA data clearly indicate delayed discharges are reaching crisis levels. The average length of stay in hospitals has increased 19.2% across the board for patients in 2022, as compared to 2019 levels.[1]

In most cases, these are our patients who are admitted to the hospital and 'boarded' in the Emergency Department. Worse yet, many of our patients sit in a waiting room until they can receive the care they need in the hospital. Hospitalists see first-hand the negative impact our patients experience when they are cared for in a location that is not designed, or staffed, to provide complex inpatient care. Once a decision is made to admit a patient, hospitalists generally assume care of that patient, allowing emergency physicians to tend to the constant flow of new patients into the emergency department. From the hospitalist perspective, our patients do not get the care they require while being boarded in the emergency department (ED). As pointed out in the ACEP letter, emergency department nurses are often burdened with caring for several boarded patients while simultaneously attending to the needs of multiple new patients who have not yet been evaluated or stabilized. Moreover, emergency department nurses necessarily have a different focus and refined skills specific to the unique dynamics of the emergency department, and are

[1] American Hospital Association (December 2013) *Issue Brief: Patients and Providers Faced with Increasing Delays in Timely Discharges. https://www.aha.org/system/files/media/file/2022/12/Issue-Brief-Patients-and-Providers-Faced-with-Increasing-Delays-in-Timely-Discharges.pdf*

unpracticed in protocols and assessments that are standard for floor nurses. As a result, hospitalists spend much of their day ensuring orders placed for patients in the ED are completed in a timely and properly manner. Likewise, patients who are boarded in the ED often do not receive many other services important for their care, including case management and physical and occupational therapy. The ED setting has limitations that are not conducive to the high-quality care our hospitalized patients deserve.

Hospitalists care for patients from admission to discharge and have a clear perspective on factors that prevent the continuous movement of patients through the hospital and contribute to the crisis of boarding admitted patients in the ED. Boarding admitted patients in the ED is demonstrative a of longstanding problems for which SHM has been long advocating, including addressing inadequate staffing, moving away from unsustainable funding models, and eliminating unnecessary barriers to post-acute care.

Inadequate staffing, rather than insufficient bed availability, is the primary problem with patient flow in the hospital. Inadequate staffing leaves beds unable to be utilized for patient care. While this issue primarily the issue stems from a nursing shortage, the physician shortage has become an increasingly large factor. Unfortunately, legislation designed to help address these shortages, including The Healthcare Workforce Resilience Act (H.R. 2255/S. 1024), remain in committee. In addition, financial hardships in hospitals and hospitalist groups, exacerbated by the pandemic, make it harder to hire staff in a competitive market caused by these shortages. Delays in or refusals of payment from payors, as well as inadequate reimbursement rates for general inpatient medical care contribute to financial strain. These problems will be intensified in the coming year, as projected payment reductions for Medicare reimbursements, including Pay-As-You-Go and budget neutrality adjustments, are expected to result in an approximate 8.4% payment cut in January. Similar cuts will be suffered by our emergency department colleagues.

Movement from the emergency department to the medical floors is also hindered by barriers that prevent patients already on the medical floor from moving out of the hospital and into a safe discharge. For example, often a patient is stable to be discharged but still requires weeks of continued care such as long-term intravenous antibiotics or intensive rehabilitation. Discharging that patient would open a floor bed for one of the boarded patients in the emergency department. However multiple obstacles stand in the way of that safe discharge, including inappropriate delays by insurers and insufficient post-acute facilities or home health providers.

SHM has raised these issues in prior communications with the Centers for Medicare and Medicaid Services (CMS) and with members of Congress. Certain insurance providers impose prior authorization requirements on transfers from hospitals to skilled nursing or other post-acute facilities. While these requirements can be appropriate checks on proper utilization of services, they are frequently used as tools to delay or deny necessary medical care. Delays and denials are particularly egregious with Medicare Advantage (MA) plans, which cover an increasingly large percentage of seniors. While the rationale behind prior authorization is to ensure a patient is medically stable enough to receive care at a lower level, the prior authorization process ultimately results in increased and unnecessary time spent in the acute care setting. Patients in need of post-acute care often wait three or more days for prior authorization under MA plans. To further complicate matters, MA plans commonly utilize third-party reviewers to process prior authorization requests. These third-party reviewers frequently deny physician

requests for post-acute services, which are then usually overturned by the payor following an appeal. The period between request, denial, and subsequent appeal(s) constitutes significant additional and uncompensated work for physicians and further contributes to unnecessarily prolonged stays in the hospital. Furthermore, the prior authorization process contributes to physician frustration and increased patient distress, while prolonged inpatient stays lead directly to increased boarding of acutely ill patients in the emergency department.

Even when post-acute care is approved by the payor, finding available bed space in post-acute facilities is an additional challenge. Nursing home closures precipitated by rising costs, COVID-related financial disruptions, and reduced reimbursement rates are a major impediment to finding skilled nursing facility (SNF) placement for patients. Many remaining SNFs are already full, making it extremely difficult to find a SNF with availability. This scarcity is heightened in underserved and rural communities. Even if SNF beds are available, hospitalists report additional barriers for placing certain patients, including those covered by only Medicaid or who are uninsured, dialysis patients, bariatric patients, patients with psychiatric problems or history of incarceration, patients requiring treatment for substance use disorders, cancer patients undergoing expensive chemotherapy, and patients enrolled in MA plans, which often have limited networks and may not adequately reimburse for the patient care provided. Staffing shortages impact every portion of this system, including the ability to transfer patients by ambulance to an accepting facility, sometimes delaying discharge by days. The inability of these patients to receive care at the appropriate clinical setting or level prevents safe discharge and further contributes to unnecessarily prolonged hospital stays, increasing the need to board patients in the ED.

In other circumstances, a patient cannot be safely admitted because the hospital does not have the required specialists on staff. When attempts are made to transfer the patient to a hospital with the necessary specialists, i.e. to a "higher level of care" such as a tertiary center, multiple barriers impede transfers. Sometimes the issue is prior authorization by insurers, which often inappropriately delay or deny care, as noted above. In other cases, tertiary hospitals must decline the patient because they themselves do not have beds available, which is sometimes a result of prior authorization requirements preventing the transfers of stable patients out of the tertiary center and back to their home institutions. Current realities and the interpretation of the Emergency Medical Treatment & Labor Act (EMTALA) make it even harder to transfer a patient if they are formally admitted to the hospital, rather than officially remaining an outpatient in the ED, which can make ED boarding a necessary, but still inappropriate, option for the patient.

ACEP's letter aptly highlights the misaligned incentives that lead to these problems. The COVID-19 pandemic revealed the unsustainability of the funding model of our healthcare system, where elective surgical care is financially favored and reimbursement rates for non-surgical life-saving care are insufficient to maintain normal financial operations. However, the pandemic also highlighted ways in which the government can help alleviate these problems, not only through targeted funding, but with administrative flexibilities that remove barriers to the proper flow of care. For example, during the pandemic, CMS relaxed prior authorization requirements for transfers between levels of care to free up acute care beds. These measures successfully reduced unnecessary hospital days and helped ensure patients were being treated in facilities with appropriate levels of care.

We join with ACEP and those who supported ACEP's November 7, 2022 letter. We agree with ACEP that ED boarding and the systemic factors contributing to the problem have risen to the level of a public health emergency. We ask your Administration to apply the same degree of urgency and creativity to abating this crisis as was applied to addressing the pandemic. These are problems that can be solved with political will and the willingness to make changes to a system that is at a breaking point. SHM stands ready to collaborate to identify solutions in order to provide the best care for our patients and would welcome the opportunity to take part in ACEP's proposed summit of stakeholders.

Sincerely,

Rachel Thompson, MD, MPH, SFHM, FACP
President
Society of Hospital Medicine

cc: The Honorable Xavier Becerra, Secretary, U.S. Department of Health and Human Services
The Honorable Alejandro Mayorkas, Secretary, U.S. Department of Homeland Security
The Honorable Sean McCluskie, Xavier Becerra Chief of Staff