

April 14, 2020

Alex Azar  
Secretary  
Department of Health and Human Services  
200 Independence Avenue SW  
Washington DC 20201

Dear Secretary Azar:

On behalf of our 39,000 members, the American College of Emergency Physicians (ACEP) thanks you for your continued efforts to respond to the novel coronavirus (COVID-19).

Last week, the Department of Health and Human Services (HHS) distributed \$30 billion of the \$100 billion Public Health and Social Services Emergency Fund appropriation that was included in the Coronavirus Aid, Relief, and Economic Security (CARES) Act to health care providers proportionately based on their 2019 Medicare fee-for-service (FFS) payments. While ACEP appreciates HHS' attempt to release the funds as quickly as possible, we have some overarching concerns with it and seek clarification on the approach used. Our principal concerns include:

- ***Disproportionate Allocation to Hospitals:*** Since hospitals receive the highest Medicare payments, they received the majority of the \$30 billion in funding. However, most emergency physicians are not directly employed by hospitals. Rather, they are often in independent groups that contract with the hospital to provide emergency department (ED) coverage 24/7, 365 days a year. And while it is often assumed that because they work in hospitals, any financial aid to those entities would sufficiently cover emergency physicians' needs as well, this is simply not the case. When an emergency physician is exposed to COVID-19, their group not only has to cover that physician's sick leave, but it must also maintain full coverage of the ED which often requires hiring temporary help to fill that gap. This locum tenens support is often more expensive as well. Thus, the emergency physician group is under greater financial strain and risk that aid to hospitals cannot address, and additional funding is needed to adequately maintain the health care safety net that all Americans rely on.
- ***Physicians Caring for Underserved Populations Did Not Receive Support:*** Health care professionals who see fewer Medicare patients and have a higher case load of Medicaid and uninsured patients were not prioritized during this first wave. [According to recent reports](#), these professionals likely work in areas with the highest number of cases of COVID-19, and therefore may be in the most need of support.
- ***Unclear and Onerous Terms and Conditions for Funding.*** Acceptance of the money is tied to numerous restrictions.

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With respect to our last concern about the terms and conditions associated with the initial wave of funding, the 10-page [terms and conditions document](#) HHS released includes a few provisions that may be difficult, if not impossible, for emergency physician groups to operationalize. As stated in HHS' [fact sheet](#) on the funding, the providers or groups that received funding last week must agree with the terms and conditions within 30 days of receipt of payment. If groups do not want to comply with the terms and conditions, they must contact HHS within this 30-day period and return the full payment. Since some emergency physician groups who received this funding are already beginning to think about how to appropriately allocate it, we believe it is critical that they are fully aware of and understand all the intricacies of the terms and conditions so that they do not unknowingly violate any of them.

Our specific questions and concerns on the terms and conditions include:

- ***“The Recipient certifies that it will not use the Payment to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse.”***
  - We seek confirmation that this condition does not preclude providers from applying for and receiving funding from other federal programs, including the Small Business Administrations' Payroll Protection Program—or receiving an advance payment through Medicare's expanded advance payment program. The COVID-19 pandemic has had a far-reaching impact on emergency physicians and their groups. ED volumes are down as much as 50 percent in some areas of the country that have not yet been hit by the virus, and groups are struggling to meet payroll. Further, there are other routine infrastructure and administrative expenses that groups are unable to afford. In all, emergency physician groups will need to use multiple funding streams to maintain existing operations and readiness. We do agree that separate funding source should be used to cover different expenses, and we therefore expect emergency physician groups to track how each source of funding is being specifically allocated.
- ***“Accordingly, for all care for a possible or actual case of COVID-19, Recipient certifies that it will not seek to collect from the patient out-of-pocket expenses in an amount greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network Recipient.”***
  - We agree that, especially at this time, it is paramount to protect patients and reduce barriers, even if just perceived, for patients to seek and receive emergency assessment and care for possible COVID-19. With respect to legislative actions over the past 18 months on “surprise billing,” we have consistently advocated for an approach that takes patients out of the middle and holds them harmless regardless of whether emergency care is provided in- or out-of-network.  
  
But while this provision of the terms and conditions states that out-of-network providers would not be allowed to collect additional payment from patients beyond what would have been their in-network cost-sharing responsibility, **there is not any guidance or direction on what amount (if any, seemingly) the insurer would be required to reimburse the provider for COVID-19 related treatment. We strongly urge you to provide additional clarification that directs the insurer to reimburse the clinician for the services provided.**
  - We also recognize that the Centers for Medicare & Medicaid Services (CMS) released [guidance on April 11](#) that highlights insurer coverage and cost-sharing requirements for certain COVID-19-related services. Specifically under the guidance, cost-sharing is waived for visits, including ED visits, that lead to an order for or the administration of a COVID-

19 test. The guidance further confuses our interpretation of this provision of the terms and conditions—and we want to make sure we fully understand the implications of COVID-19 cost-sharing and coverage requirements on the contingencies placed on the \$30 billion.

- The guidance states that if a plan or issuer does not have a negotiated rate with a provider, the plan or issuer shall reimburse the provider in an amount that equals the cash price for such service as listed by the provider on a public internet website, or the plan or issuer may negotiate a rate with the provider for less than such cash price.
  - We have multiple concerns about posting cash prices for emergency care on a public website:
    1. It could lead to anticompetitive behavior by competing groups once they are aware of the rates that their competitors have listed.
    2. It could have unintended effects on the local health care market by giving insurers an unfair advantage in future contract negotiations. Some legal complications, relating to the Sherman Antitrust Act, may also arise in certain cases.
    3. We want to reiterate [previous concerns](#) we have shared with CMS about the potential implications of posting prices with regard to the Emergency Medical Treatment and Labor Act (EMTALA). EMTALA stipulates that a hospital may not place any signs in the ED regarding the prepayment of fees or payment of co-pays and deductibles which can have the chilling effect of dissuading patients from “coming to the emergency department.” To do so could lead patients to leave prior to receiving a medical screening examination and stabilizing treatment without regard to financial means or insurance status, which is a fundamental condition for satisfying EMTALA, and one of the most foundational principles of an important patient protection that was enacted three decades ago. If we attempt to get pricing information to patients prior to stabilizing them, not only would that be an EMTALA violation, but it could also potentially cause the patient’s health to deteriorate since it could delay the patient from receiving critical care. While the penalties for violating EMTALA are steep, our bigger concern is that if transparency for emergency care is not approached carefully, we could inadvertently be putting our patients in a position of making life-or-death health care decisions based on costs, rather than need.

In light of these concerns, we request that HHS issue an overarching statement that clarifies that the posting of cash prices will in no way violate any existing provisions of federal law.

- Please explain how this negotiation process would occur, and what guardrails are included in the process. Would it be ultimately up to the plan to decide what was a fair payment for a service? What would happen if there were no agreement? Would the plan be required to pay the provider a minimum amount if the plan did not agree to the provider’s cash price?

- Please clarify whether the insurer’s payment to providers for these visits INCLUDE this cost-sharing amount. In other words, if a patient’s cost-sharing obligation is typically 20 percent of the cost of the service, it should now be specified that insurers cover that amount in their payment to providers. We cannot as a “quick fix” just shift the burden of cost-sharing from the patient to the frontline emergency physician, which would be extremely unfair to those risking their lives each day caring for patients in this pandemic.
- As stated above, cost-sharing is only waived for visits that *lead* to an order for or the administration of a COVID-19 test. However, for an ED visit, there is simply no way to parse out from billing which services are provided to a patient before or after a test was ordered or administered. Therefore, we seek confirmation that insurers must cover all services provided in such an ED visit in order to comply with CMS’ guidance.
- ***“None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II.”***
  - ACEP strongly opposes this requirement, as it effectively locks groups out from being able to use this funding to cover payroll for any of their physicians. According to the [Office of Personnel Management \(OPM\)](#), the annual salary of an Executive Level II in 2020 is \$197,300. Most of our members, emergency physicians who have extensive training and are board-certified in emergency medicine, have annual incomes above this arbitrary threshold. It is unethical for HHS to restrict the use of funding to help these heroes keep their jobs, especially at a time when our country needs them most. However, if HHS has no choice but to go forward with this condition, we request that emergency physician groups be provided the flexibility to take into account the fact that their individual physicians’ incomes have drastically decreased due to the devastating impact of the COVID-19 crisis and may, in all likelihood, now be less than this threshold.

We respectfully ask that HHS address these questions in a timely manner, so that we can provide responses to our members in enough time for them to carefully consider the terms and conditions prior to the end of the 30-day deadline.

Lastly, we recognize that HHS is planning on a second wave of funding that hopefully will address at least some of these concerns, and we would like to reiterate [our previous request](#) for \$3.6 billion of the remaining funding to be specifically allocated towards emergency medicine groups and to the emergency physicians who practice within them, who are repeatedly risking their lives combatting the virus and are at the highest risk of being exposed and missing work. In all, additional funding is needed to adequately maintain the health care safety net that all Americans rely on.

If you have any questions, please contact Laura Wooster, ACEP’s Associate Executive Director of Public Affairs at [lwooster@acep.org](mailto:lwooster@acep.org).

Sincerely,



William P. Jaquis, MD, MSHQS, FACEP

ACEP President