Q & A Remaining from 4/23/20 Webinar

Would liability protection cover physicians caring for example a STEMI or stroke during this pandemic, i.e. a non COVID patient but during a shift that COVID patients were presenting?

(and)

Is liability protection being requested just to cover COVID patients or all patients treated during the COVID pandemic? i.e., the STEMI that has delayed treatment due to Cardiologist concern for taking pt to cath lab?

Getting Congress to address medical liability protections has always been challenging for a number of reasons. However, under these extraordinary conditions, we have found that some lawmakers who are not normally interested in this issue have expressed an interest in considering liability protections because of the COVID-19 crisis. Because this interest is reflected in how physicians provide care due to the unique circumstances of COVID-19 (lack of beds, equipment, medications, testing, etc.), the liability protections we are promoting, in conjunction with the AMA, nearly 90 other physician specialty organizations, and all state medical societies, would be related to either direct care to a COVID patient OR care that was altered indirectly because of the strains COVID-19 has placed on physician and resource availability. Our proposed solutions for temporary liability relief during the COVID-19 crisis would not extend to patients who receive care that is unrelated to COVID-19 or whose care is unaffected by COVID-19 considerations.

We are particularly worried about hospital funding and hospital solvency in our smaller, more rural areas. Many of these hospitals operate on thin margins and have little or no financial flexibility to absorb this. Do we have messaging about supporting these facilities that will support so much of our country?

The CARES Act and other planned funds are directed to go to “providers”, meaning both hospitals and physicians. The hospitals have been advocating heavily for the funding they need, and we’ve actually had our hands full just trying to get a sufficient portion of these funds for physicians, since they are distributed from the same accounts. You may even have seen how many media articles and summaries of the legislation after it passed referred to it as “the hospital fund” or only referenced hospitals receiving the money.

Generally, we are conveying a message that Congress needs to provide appropriate financial resources to physicians, facilities, and all aspects of the health care system, to ensure they will still be available to provide medical care in their communities, both during the COVID-19 crisis, as well as after the immediate crisis is over, and have highlighted how rural areas are especially hard hit by the loss of revenue from volume drops.

If we are to advocate for full utilization of the Defense Protection Act, what are specific actions that could be taken, or we would advocate to be taken? (Perhaps we will not be asked about this specifically, mostly curious about how fully it has been implemented relative to its full potential)

The DPA is a Korean War-era law that essentially gives the federal government a range of authorities, including issuing loans to expand a vendor's capacity, controlling the distribution of a company's products, and compelling companies to prioritize the government's order over those of other clients. We are asking that the federal government view our current needs for medical supplies in the same way it has for military equipment.

Specifically, we are urging the federal government to fully utilize this authority, in combination with its emergency response capabilities, to: (1) help identify what shortages exist – nationally, regionally, and locally – of critically needed supplies, such as PPE, ventilators, medications, etc.; (2) work with companies to ensure those shortage materials have priority production; and (3) coordinate the distribution of these supplies to most appropriate areas of need.

I have heard that health insurers are indeed paying for the tests but deeply discounting the payment. Is there any way to argue for cost-based payment?

On April 14, ACEP wrote a letter to Department of Health and Human Services (HHS) expressing our concern about a number of issues, including the lack of clarity around what health insurers are required to reimburse physicians for services rendered to patients with confirmed or suspected cases of COVID-19. HHS, in conjunction with the Departments of Labor and Treasury, put out guidance/FAQs on coverage and cost sharing requirements. According to the guidance, health plans are supposed to cover the cost of an ED visit that results in an order for or administration of a COVID-19 test. For these visits, the guidance states that if the health plan does not have a negotiated rate with a provider, the plan or insurer must reimburse the provider in an amount that equals the cash price for such service as listed by the provider, or they may negotiate a rate with the provider for less than such cash price.

There is a lot of ambiguity here, so we have asked HHS to clarify the following points:

- How the negotiation process for OON payments would occur, and what guardrails are included in the process.
- Whether the entire ED visit must be covered. As stated above, cost-sharing includes ED visits that lead to an order for 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 have asked HHS to confirm that insurers must cover all services provided in such an ED visit in order to comply with the guidance.
- Whether the insurer's payment to providers for these visits include the patient's cost-sharing amount that has now been waived. In other words, if a patient's cost-sharing obligation is typically 20 percent of the cost of the service, we want to make sure that insurers must cover that amount in their payment to providers.

We are still waiting for responses to these questions and will continue to provide updates on this and other reimbursement issues on our website: www.acep.org/covid19

Please describe process of how priorities for the Hill Day are selected?

The issues we select to advocate for in your Hill visits are carefully selected based on numerous factors, so they might sometimes seem to not reflect an issue that is of highest priorities for parts, or even all, of our membership. We have limited time in these calls and can only talk about a few items and still be effective, so it's important for us to triage appropriately.

A key factor in choosing an issue is the ability for us to move the needle on it—this is based on our assessment of the current environment in Congress, what legislation is being considered or could be considered to move/come up for a vote under support of Congressional leadership, previous action on the issue by Congress, if any, etc. This is something that ACEP's DC staff assesses through our numerous interactions with Congressional staffers, federal administration staff, members of Congress, think tanks, etc.

Another factor we look at is if the issue can raise the profile of emergency medicine—these are what we'd call the "white hat" issues. Emphasizing the important role emergency medicine plays in providing high-quality care to a legislator's constituents builds their trust in the profession, and helps to increase our influence with them when other issues come up that we need their help on.

We emphasize to our participants how important it is for our members to keep up the advocacy during the rest of the year when they are back home, and using the training and tools developed through Virtual Hill Day to do so. This provides an opportunity and flexibility for participants to raise their own priority issues in advocacy interactions outside of our Hill Day, which we absolutely encourage.

Should we address APPs lobbying for independent practice during COVID pandemic?

We definitely understand the concern that APPs are leveraging the COVID pandemic to lobby for independent practice, and we are monitoring this issue. However, we note that the Centers for Medicare & Medicaid Services (CMS) has a lot of flexibility on the regulatory side during national emergencies and has already used their emergency waiver authority to expand the ability for APPs to practice independently. Specifically, CMS temporarily waived a Medicare hospital condition of participation which requires that Medicare patients in the hospital be under the care of a physician. According to CMS, this waiver allows hospitals to use other practitioners, such as physician's assistant and nurse practitioners, to the fullest extent possible. This waiver must be implemented in accordance with a state's emergency preparedness or pandemic plan. While this is concerning, lobbying Congress on this will be largely ineffective, given the Administration's authority to do this, and (even worse) could paint

emergency physicians in a poor light, given the difficult optics in even non-pandemic times that surround this issue.

Has there been any discussion about emergency physicians having any better or priority access to applying to the Paycheck Protection Program? Many are contractors, though the PPP has otherwise been difficult to work with. Thanks.

While emergency physicians do not have priority under the paycheck protection program, most are eligible to apply for funding. Congress just approved an additional $321 billion for the program. Independent contractors are eligible to apply for funds. Please go to the Small Business Administration's website for more details: https://www.sba.gov/funding-programs/loans/coronavirus-relief-options/paycheck-protection-program.

Would this hazard pay be tax exempt or not?

(and)

As a member of the military, if deployed to a combat zone, my pay is exempt from income tax. Could this be suggested for "hazard pay" as well?

Generally, any hazard pay is considered taxable income unless otherwise specified by law. An exception to this is that members of the Armed Forces are granted tax-free income for months they serve in designated combat zones. The Heroes Fund proposal does not include such provisions, nor have other similar proposals suggested to do so. Adding tax exemption typically reserved for men and women in uniform to our legislative request would go significantly beyond existing proposals and may appear excessive even to sympathetic legislators.

The real economic issue is a drop in ED census globally due to the public's fear of catching Covid at the Hospital. People are having their emergencies at home, even with time dependent conditions like MI, stroke, surgical problems. There is a spike in at home deaths. Is ACEP advocating on this?

Absolutely. As we noted during the webinar, ACEP has collected data showing how significant a volume drop there has been due to COVID-19 and shared that with key policymakers in the Administration and with Congressional offices.

As well, we have been messaging to the public the importance of still seeking care if you think you're having an emergency. This includes a press release on the issue, as well as an upcoming joint Letter to the Editor ACEP has planned for to appear in USA Today in partnership with a leading patient advocacy group. We also have developed a "Know When to Go" patient guides for both non-COVID conditions and COVID-related symptoms.

Lastly, we have developed a template joint letter to the editor signed by ACEP and other national medical societies to encourage the public not to delay seeking emergency care during a pandemic, and we encourage ACEP members to submit this to their local news outlets.

Should we discuss the Medical Supply Chain Emergency Act (S. 3568)?

ACEP's approach has been to encourage expanded use of the DPA, depletion of the national stockpile, use any and all options, etc. There are many who feel that while the Administration has implemented the DPA in a few areas with some manufacturers, it is isn't being used to its full extent. We looked at S. 3568 and while it has similar goals, it's essentially *forcing* the President to use the DPA in certain, specific ways, and unfortunately is completely partisan in its support.

Quite simply, this Administration (or any past Administration in our experience), will not respond well to that sort of language. ACEP is indeed amplifying our requests for a more formal role for the Feds in the identification of what resources are needed, where they are needed, and a centralized point of distribution. But rather than "directing" the President to do this (as S. 3568 does), we are trying to make a reasoned argument for why it *needs* to be done. This issue doesn't exist in isolation given the myriad requests we have before Congress and the Administration, and we therefore need to be careful on our approach.