American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

November 24, 2020

The Honorable Joseph R. Biden, Jr.
President-Elect of the United States
Biden-Harris Transition Team Headquarters
Wilmington, DE

Dear President-Elect Biden:

On behalf of our 40,000 members, the American College of Emergency Physicians (ACEP) wishes to express our congratulations to you, President-Elect Biden and Vice President-Elect Harris, and wants to thank you for your ongoing work to ensure that your incoming administration is prepared to take over the federal response to the novel coronavirus (COVID-19) public health emergency (PHE) as soon as you take office on January 20, 2021.

As you well know, we are facing the most devastating health care crisis in a generation—and like you, we believe that the decisions we make as clinicians as well as the policies that are implemented at the federal, state, and local levels all must be evidenced-based and rooted in science. The situation on the ground is constantly changing, and since March, we have worked diligently to update our emergency physician members and the patients we serve with critical information needed to ensure effective care can be safely provided. As part of that effort, we established a COVID field guide, which tens of thousands of individuals have turned to for the most up-to-date guidance on emergency care policies and clinical protocols.

While we have made a lot of progress tackling the pandemic, more work needs to be done as we face some of the highest rates of new COVID cases and hospitalizations that we have experienced thus far. ACEP has identified key policy gaps and challenges that we hope you will consider prioritizing going forward. Addressing these issues will give front-line health care workers the resources and flexibility they need to protect themselves and treat their patients during the difficult weeks and months that lie ahead.

These major issues include:

- Creating an Effective and Safe Vaccine Distribution Strategy for Emergency Departments (EDs) and Emergency Medical Service (EMS) Agencies;
- Continuing to Ensure Coverage and Full Elimination of Cost-Sharing of Testing and Services Related to the Treatment of COVID-19;
- Improving Access to Point of Care Testing in the ED
- Protecting Front-line Health Care Workers by Increasing the Availability of Personal Protective Equipment;
- Securing a Stable Workforce by Reducing Barriers to Physicians and Other Health Care Providers Seeking Mental Health Treatment; and
- Providing Financial Stability So Emergency Physicians Can Continue to Treat Patients, Maintain Readiness, and be Fully Prepared for Patient Surges.

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Creating an Effective and Safe Vaccine Distribution Strategy for Emergency Departments and Emergency Medical Service Agencies

Like all Americans, we were thrilled to see the recent promising vaccine trial results from Pfizer, Moderna, and AstraZeneca. While the Food and Drug Administration (FDA) has not yet issued an emergency use authorization for a vaccine, we must start preparing now to ensure that emergency departments (EDs) and emergency medical service (EMS) agencies are ready to receive, store and handle, and safely administer a vaccine once it is approved. We believe that, depending on the community need, EDs may take different approaches to administering the vaccine. One possible option would be for medical personnel to administer the vaccine to every patient who is treated in the ED. Family members or friends of the patient waiting in the waiting room could also be offered the vaccine. Another option would be to actually establish the ED (or an outside tent) as a vaccine administration center where individuals who do not have access to a primary care physician, a pharmacy, or other health care provider could receive the vaccine. A third possible approach would be to filter patients who come to the ED to another site in the hospital where the vaccine would be administered.

Although EDs may take different approaches to vaccine administration, they will definitely play a critical role in making sure that the majority of the population in their communities is vaccinated. To help support EDs, we must ensure that we have an appropriate supply of vaccines and prioritize their delivery so that all members of emergency medicine care teams and other frontline personnel across the country receive the vaccine in the initial phase of the distribution process. We must also then ensure that EDs and EMS agencies are able to obtain an ongoing supply to administer to patients in future phases. Further, we need to have sound vaccine administration protocols in place so that emergency medicine professionals and patients are protected and can safely and efficiently receive the vaccine.

The Pfizer, Moderna, and AstraZeneca vaccines all have different storage and handling requirements. However, no matter which vaccine EDs and EMS agencies are using, they will likely need resources to comply with those requirements. Therefore, it will be important to have consistent and reliable reimbursement across public and private payors so EDs and EMS agencies can cover all associated costs and continue to administer the vaccine through all the distribution phases. Additional federal support may be warranted for facilities that serve vulnerable and under-resourced populations in order to help them establish vaccine programs and cover supply, equipment, training, and patient education costs.

Finally, we must have a comprehensive way of tracking who has taken a vaccine. The Pfizer and Moderna vaccines require two shots taken weeks apart, so it will be difficult to monitor whether individuals who received an initial shot go back and receive their second, especially if patients are initially receiving the vaccine in the ED or other facility that is not their primary place for receiving health care services. We strongly recommend that there be national, regional, or state vaccination reporting systems in place that emergency physicians and other emergency medicine professionals have access to and can use to ensure that vaccines are administered appropriately to their patients.

Continuing to Ensure Coverage and Full Elimination of Cost-Sharing of Testing and Services Related to the Treatment of COVID-19

As we try to mitigate the spread of the coronavirus, it is imperative to provide certainty for patients who may be concerned about any potential personal costs associated with tests and treatment related to COVID-19, in order to ensure they seek care and prevent further transmission. Congress has passed legislation including the Families First Coronavirus Response Act (FFRCA) and the Coronavirus Aid, Relief, and Economic Security (CARES) Act that requires public and private payors to cover COVID-19 tests and testing-related services with no cost-sharing for patients. However, even with these laws in place, private health plans have instituted inconsistent coverage policies, especially with regard to the treatment of COVID-19. These policies have left individuals diagnosed with COVID-19 and receiving significant medical treatment with large medical bills. With new therapeutics becoming available, it is essential for individuals who may have COVID-19 to be able to seek medical treatment when needed and not delay care because they are unsure what services their health plan may cover.

We also need to guarantee that COVID-19 tests and testing-related services continue to be covered and provided free of charge to individuals. ACEP strongly believes that completely eliminating the fear of potential out-of-pocket costs will help remove what could be a dangerous obstacle to more widespread testing and resulting containment of the disease.

Improving Access to Point of Care Testing in the ED

ACEP appreciates that you have laid out a robust, evidence-based testing strategy which includes ramping up testing and contract tracing. In the ED, having enhanced, unrestricted testing policies in place is critical. Many people come to the ED with undifferentiated flu-like systems and, while EDs are triaging these patients to ensure that all patients can safely receive treatment, not having an adequate supply of testing puts patients at risk. If patients are unable to get tested while in the ED due to supply shortages or restrictive testing policies that some hospitals have implemented to ration limited testing supplies, some patients may have to stay in the ED for longer than necessary, and others may in fact experience a delay in care.

Besides increasing the supply of tests, what is equally as important is ensuring that EDs have tests that can quickly provide emergency medical personnel and patients with results. In emergency situations, minutes and seconds matter, and it is not helpful if individuals have to wait a few days to find out whether they are positive. We need to have point-of-care tests readily available in EDs across the country. Being able to quickly identify COVID-positive patients will not only improve patient-flow and safety protocols in the ED, but from a public health perspective, it would allow emergency physicians and other providers to better coordinate with local and state health officials to identify potential outbreaks.

Protecting Front-line Health Care Workers by Increasing the Availability of Personal Protective Equipment

Emergency physicians and other frontline health care workers continue to risk their lives each day to provide care, but unfortunately have been forced to repeatedly reuse what are supposed to be single-use protective supplies, threatening the safety of both the health care workforce and patients alike. As we are now in the midst of another dramatic increase in COVID-19 cases and hospitalizations throughout the country, the basic supplies needed to protect the health and safety of emergency physicians and other health care workers will simply not be available in the quantities needed. Many hospitals and other health care entities are claiming they have "sufficient" stockpiles of personal protective equipment (PPE), but that is only because they have changed their protocols and require emergency physicians (and others) to utilize a single mask, or other PPE, for longer than their intended use. This significantly increases the risk of contamination and possible infection for both emergency physicians and our patients.

We understand that hospitals across the country are doing their best to implement uniform and safe PPE policies that align with Occupational Health and Safety Administration (OSHA) requirements and Centers for Disease Control and Prevention (CDC) requirements. However, in some cases physicians and other medical personnel still feel unsafe following their hospitals' protocols and wearing the PPE that is provided to them. While OSHA's PPE standard does allow physicians to wear their own PPE, some hospitals, for various reasons, are not allowing individuals to do so. Other physicians have been penalized for speaking out against their hospitals' policies. We have engaged with OSHA, the CDC, The Joint Commission (TJC) and others on this issue, including sharing personal stories from physicians about their PPE struggles. We wholeheartedly agree with the TJC's statement that supports allowing health care staff to bring their own masks or respirators to wear at work, when their health care organizations cannot provide them with adequate protection commensurate with the risk of infection to which they are exposed by the nature of their work. We ask you also to support health care workers individual right to wear PPE that they feel is necessary to keep them and their patients safe.

These PPE issues will likely remain long after a vaccine is approved. Going forward, we urge you to exhaust all options to establish a stable, reliable supply chain to ensure PPE is continuously available and can be used as intended. We support

your position of fully utilizing the Defense Production Act to maximize the production and dissemination of critically needed PPE. We also believe that you will need to reform the current strategy for distributing supplies from the strategic national stockpile (SNS). Overall, ACEP believes that must be a multi-pronged, transparent approach to re-stocking and distributing supplies from the SNS that includes proactive federal efforts and centralized coordination. ACEP's complete comments on the current administration's SNS proposed strategy can be found here.

Securing a Stable Workforce by Reducing Barriers to Physicians and Other Health Care Providers Seeking Mental Health Treatment

Although emergency physicians and other health care workers are proudly and bravely serving on the front lines, many are justifiably feeling fatigued and burned-out. Even before the COVID-19 crisis hit, emergency physicians have historically had higher rates of career burnout and post-traumatic stress disorder (PTSD) than other medical specialties. Upwards of 65 percent of emergency physicians and emergency medicine resident physicians report experiencing burnout during their career. While approximately 15 to 17 percent of emergency physicians, and upwards of 20 percent of emergency medicine residents, met the diagnostic criteria for PTSD in 2019. Further, in the last year, as many as 6,000 emergency physicians have contemplated suicide and up to 400 have attempted to take their own life.

Now with the pandemic raging on, these unsettling trends in emergency medicine have only gotten worse. Unfortunately, although emergency physicians should be encouraged to ask for help and seek counseling and other mental health services when they need them, the way the system is designed leaves many legitimately afraid to do so. Overall, physicians seeking mental health treatment are concerned about possibly losing their medical licenses or facing other professional setbacks. Some state licensing boards continue to ask intrusive questions about physicians' mental health histories or past treatment that appear to violate the intent of the American Disabilities Act—which prohibits discrimination against people with disabilities, including psychiatric disorders. These intrusive questions about whether physicians have *any* psychiatric history have discouraged many who need psychiatric treatment from seeking it because of fear of the questions down the road that could impact license renewals and their ability to practice medicine. Practicing physicians with histories of psychiatric disorders or mental health counseling have at times also faced discrimination with respect to receiving hospital credentials and privileges.

In October, ACEP released a poll in conjunction with Morning Consult that puts hard numbers behind this extremely troubling reality. The poll shows that emergency physicians' stress levels have dramatically increased during the COVID-19 pandemic. More than eight in ten (87 percent) of emergency physicians report feeling more stress since the start of COVID-19. Additionally, 72 percent report experiencing more professional burnout. The poll gives us the first authoritative look at the causes of stress or burnout on the frontlines since the start of COVID-19. Four in five emergency physicians cite concerns about family, friends, and personal health as causes for stress or burnout since the start of COVID-19. Further, three in five emergency physicians cite concerns for job or financial security and lack of personal protective equipment.

Notably, *nearly half* (45 percent) of emergency physicians report that they are not comfortable seeking mental health treatment if needed. However, interestingly, the poll shows that 71 percent of emergency physicians say they have "good" or "excellent" access to mental health treatment, which suggest that access itself is not a main barrier to emergency physicians deciding to seek mental health treatment. But 73 percent of emergency physicians feel there is stigma in their workplace when it comes to seeking it.

These concerns put many emergency physicians in an impossible position of feeling they have to choose between their health and their career. Nearly 60 percent of emergency physicians report they would be concerned for their job if they

were to seek mental health treatment. In addition, more than a quarter report they have avoided seeking mental health treatment in fear of professional repercussions.

ACEP has made addressing these disturbing trends and statistics a top priority. Earlier this year, we met with TJC to discuss current barriers physicians face seeking mental health treatment. Just a few short weeks later, TJC put out a statement encouraging organizations to not ask about past history of mental health conditions or treatment and supporting the elimination of policies that reinforce stigma and fear about the professional consequences of seeking mental health treatment. ACEP also spearheaded the development of a joint statement with over 40 leading medical organizations, including the American Medical Association and the American Psychiatric Association, that outlines recommendations for removing existing barriers to seeking treatment, including the fear of reprisal and better encouraging professional support and non-clinical mental health initiatives, such as peer support, for physicians.

We are especially honored to have partnered with the Dr. Lorna Breen Heroes' Foundation to advocate for legislation such as the *Dr. Lorna Breen Health Care Provider Protection Act* and other efforts to dismantle barriers for physicians seeking mental health treatment. The legislation is named in honor of an emergency physician who tragically died by suicide earlier this year after treating COVID-19 patients in New York City and contracting the virus herself. It would take major steps to reduce and prevent suicide and burnout by creating behavioral health and well-being training programs and requiring a national study on barriers to treatment such as stigma. It would also support a national campaign to encourage health care professionals to seek support and treatment. ACEP also supports the bipartisan *Coronavirus Health Care Worker Wellness Act of 2020,* which would authorize the Secretary of the Department of Health and Human Services to make grants that would establish or expand mental wellness programs for workers on the front lines of COVID-19.

Going forward, we hope to partner with you on these efforts and explore other ways to tackle the barriers to mental health treatment and support our front-line workers. We need to strongly enforce the American Disability Act, take a critical look at existing state licensing and hospital credentialing policies, invest in mental health treatment programs and support hotlines, and work together to reduce the stigma among the medical community around seeking help.

Providing Financial Stability So Emergency Physicians Can Continue to Treat Patients, Maintain Readiness, and be Fully Prepared for Patient Surges

During the COVID-19 PHE, emergency physicians and their colleagues have not been immune from the economic consequences of reduced volume and income that hospitals and physicians of all types have been facing. While it may seem counterintuitive, EDs across the country have experienced a significant reduction in volume since the pandemic began. Based on data from the CDC, ED volumes dropped by around 40 percent in April compared to what they were in April of last year. Comparing 2020 to 2019 for the rest of the year, ED volumes are starting to pick back up, but the monthly averages are still down roughly 10 percent. While the initial reduction in ED volume was caused in part by government's call to stay at home during the first stages of the pandemic, we have also unfortunately seen that individuals that needed to seek immediate care for medical emergencies either delayed care or avoided care altogether due to a fear of being exposed to COVID-19 while in the ED.

Besides lower ED volumes, it has also been more expensive than usual to provide appropriate care to the patients who have in fact come to the ED. Some emergency physicians work at academic medical centers where they are salaried employees of a hospital. However, most are actually not employed by hospitals directly, but rather work for independent groups of all sizes that contract with the hospital to provide emergency services in the ED. The majority of hospitals have not provided any financial support to these independent groups during the COVID-19 pandemic to help the groups cover any losses or increased expenses.

Independent emergency physician group practices have had to incur additional expenses for treatment, such as developing and implementing necessary but time-consuming protocols for alternative sites of care, enhancing telehealth capabilities, purchasing PPE, and taking on other new administrative costs (such as triaging and treating patients with potential COVID symptoms in ways that limit possible exposure to the disease). Further, when an emergency physician is exposed to COVID-19, his or her group not only has to cover that physician's sick leave, but must still 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.

All of these additional costs are weighing down on group practices as they try to maintain the minimum staffing levels necessary to serve patients night and day in the ED and prepare for surge staffing when COVID-19 cases actually do increase in their area. Thus, with less revenue from ED volume reductions, emergency physician groups are struggling to meet these coverage requirements. In a recent ACEP member survey, a fifth of respondents said that their group has laid off a physician, nearly a third said that their group had furloughed a physician, and over half stated that their group has cut their pay for the same work. Even salaried employees of hospitals have experienced pay cuts and reduced shift hours due to the financial pressure placed on hospitals during this difficult time.

While emergency physicians have received some financial support from federal programs, such as the Provider Relief Fund, for many groups these resources have only covered a small fraction of their overall lost revenues and decreased expenses due to COVID-19. We have repeatedly requested that $3.6 billion be specifically allocated from the Provider Relief Fund towards emergency medicine groups and to the emergency physicians who practice within them.[1] However, we estimate that emergency physician groups have thus far received a small fraction of this $3.6 billion need. Instead, much of it has gone to hospitals with the assumption that it would flow down to these emergency physician groups—something that has not borne out.

Looking forward, many emergency physicians are very concerned about the viability of their groups. This fear has been exacerbated by a pending Medicare reimbursement cut in 2021. The Centers for Medicare & Medicaid Services (CMS) will likely finalize a policy under the Medicare physician fee schedule (PFS) that the agency estimated would result in a 6 percent cut in reimbursement to emergency physicians and other emergency health care practitioners. This cut results from a previous regulation that would increase the primary care office and outpatient evaluation and management (E/M) services and add a new add-on code for complexity for these services (GPC1X) in 2021. To preserve budget neutrality as required by law, CMS must significantly reduce the PFS conversion factor by 10.6 percent in—dropping it to one of the lowest levels it has been in 25 years.

We understand that this cut, if finalized, would go into effect on January 1 prior to your taking office. However, we wanted to emphasize that this reduction in combination with the other financial hits emergency physician groups have already been taking could potentially jeopardize the nation's critically-needed safety net during this pandemic. At a time when emergency physicians are risking their lives to combat this disease, they should not also be worrying about being able to keep the ED doors open.

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[1] ACEP has written four letters to the Secretary of the Department of Health and Human Services (HHS) regarding the allocation of the Provider Relief Fund. On March 27, 2020, ACEP sent a letter asking that HHS prioritize funding for frontline health care workers, especially emergency physicians, who are risking their lives combating the virus and are at the highest risk of being exposed to COVID-19 and missing work. On April 3, 2020, ACEP sent a follow-up letter specifically requesting $3.6 billion to support emergency physician practices. On April 14, 2020, ACEP sent another letter reiterating our previous requests and expressing our questions and concerns about the initial $30 billion wave of funding and the associated terms and conditions that health care providers must agree to keep their share of the funds. Finally on June 1, 2020, ACEP wrote a letter asking that HHS reserve a portion of the $75 billion that Congress provided in the Paycheck Protection Program and Health Care Enhancement Act to cover the remaining balance of the $3.6 billion request.

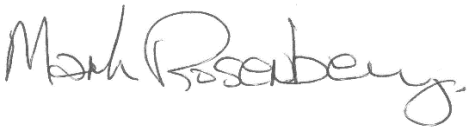
Along with financial security, we believe additional regulatory flexibility and liability protections are necessary for physicians to continue to dedicate their time and limited resources to their patients. As cases surge, we unfortunately have to plan for the worst in that a continued strain on medical resources may require there to be a shift in care. Rather than doing everything possible to try to save every life, it may become necessary to allocate scarce resources (such as medications, ventilators, etc.) to save as many lives as possible. Your incoming administration should review and consider various scenarios where health care professionals should be held free from liability during this crisis. The outgoing administration provided liability immunity to manufacturers, distributors, certain non-emergency healthcare providers, and other entities. We urge you to extend reasonable immunity temporarily to emergency physicians and other frontline personnel to ensure greater flexibility and capacity to treat more patients.

With respect to regulatory flexibility, CMS has already waived numerous regulatory requirements, including reporting obligations under its quality performance programs. The major reporting program for physicians in Medicare is the Merit-based Incentive Payment System (MIPS). We ask that you consider extending existing flexibilities for MIPS reporting for both 2021 and 2022.

We appreciate the opportunity to share our concerns and priorities, and we are eager and willing to work with you and be a resource to your incoming administration. We all share the goal of making sure that American's health care safety net is fully functional both now and in the future. Therefore, for the safety and wellbeing of the American public, we hope that you will make it a priority to support and protect every emergency physician and the millions of patients we all serve during this difficult time.

If you have any questions, please contact Laura Wooster, ACEP's Associate Executive Director of Public Affairs at lwooster@acep.org.

Sincerely,



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