March 20, 2020

Michael Richard Pence
Vice President of the United States
Chair, White House Coronavirus Task Force

Dear Vice President Pence:

In these unprecedented times of a WHO-declared global pandemic, first Stafford Act emergency encompassing all of the United States, and a 319 public health emergency, emergency physicians are on the front line of the response to COVID-19. As the canary in the coal mine, we can already foresee potential challenges in assuring the most appropriate emergency response to ensure the best care in the time of crisis. Patient access and accessibility to qualified healthcare professionals is foremost in our concerns. Given that, we have three key sets of recommendations – expansion of the waiver process, addressing surprise insurance gaps, and addressing other funding needs.

**Waivers**

While we appreciate the Stafford Act emergency declaration made by the President on March 13 and the Secretarial determination of a public health emergency effective January 27, which provided the authority for the Centers for Medicare and Medicaid Services (CMS) to issue blanket waivers under section 1135 and 1812(f), we remain concerned that these blanket waivers are not sufficient to deal with the breadth and depth of the issues involved. We understand that States may opt, and have started to submit applications to that effect, to address additional challenges. However, rather than rely upon state-by-state responses, we urge you to issue additional blanket waivers to address these key issues. Specifically, we would like you to address issues related to EMTALA, telemedicine, and free-standing emergency centers, as well as additional remedies related to Medicare quality data reporting.

**EMTALA**

During an emergency, it will likely be prudent to redirect patients away from the emergency department and to select screening and testing sites. Unfortunately, CMS’ March 9 memo regarding the Emergency Medical Treatment and Active Labor Act (EMTALA) still requires all emergency departments to conduct an appropriate medical screening evaluation (MSE) before allowing the patient to be appropriately directed or re-directed to another site of care. This requirement directly conflicts with many of the State emergency response plans. And, it seems inconsistent with Secretary Azar’s explicit waiver (from March 13 but retroactive to March 1) that states that the following items should be waived:

> Sanctions under section 1867 of the Act (the Emergency Medical Treatment and Labor Act, or EMTALA) for the direction or relocation of an individual to another location to
receive medical screening pursuant to an appropriate state emergency preparedness plan or for the transfer of an individual who has not been stabilized if the transfer is necessitated by the circumstances of the declared Federal public health emergency for the COVID-19 pandemic.

Already, Washington State, which has been hard hit by COVID-19, has requested a full suspension of EMTALA. Specifically, the state has requested a waiver to “[s]uspend enforcement of section 1867 of the Social Security Act (the Emergency Medical Treatment and Active Labor Act, or EMTALA). This will allow hospitals to screen or triage patients at a location offsite from the hospital’s campus and transfer patients according to protocols that account for COVID-19 status, not just according to existing transfer requirements.” Again, EDMPA urges CMS to provide a blanket waiver to this effect, rather than require that States make this request on an ad hoc basis. Or, at the very least, EDMPA urges the Administration to provide consistent messaging regarding the application of EMTALA during this time.

**Telehealth/Remote Patient Services**

Congress recently recognized the value of expanded telehealth/telemedicine services during this pandemic, with the authorization of a new CMS tool – the *Telehealth Services During Certain Emergency Periods Act of 2020* as part of the *Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020* (Public Law No: 116-123). While we appreciate the CMS announcement on March 17 related to telehealth (i.e., press release, fact sheet and updated FAQ), there are still key gaps. Specifically, ED physicians are not able to provide and be reimbursed for Emergency Department (ED) evaluation and management (E/M) codes via telehealth because the ED E/M CPT codes do not appear on the list of approved telehealth services as maintained by the Centers for Medicare and Medicaid Services. As you are well aware, the brunt of the current crisis will fall on emergency departments. It is our understanding that CMS has directed emergency providers seeking to provide services via telehealth to use other codes that already appear on the Medicare list of approved telehealth services, including the office and outpatient evaluation and management (E/M) visit codes. CMS has also highlighted that the critical care consult codes, psychiatric diagnostic evaluation codes, and psychotherapy for crisis codes are also already on the Medicare list of approved telehealth services.

We are concerned that, without further changes, the guidance provided regarding telemedicine in the emergency setting will continue to provide a barrier to care in the current crisis. First and foremost, we believe that it will be important for the Administration to clarify that emergency services (whether an E/M visit, tele-triage in the ED, tele-screening) is still considered an “emergency service” regardless of which CPT code or Place of Service (POS) code is submitted on a claim form. In addition, many of the provisions that the Administration has already instituted to facilitate the utilization of telemedicine in the face of the COVID-19 pandemic have been presented in the form of “non-enforcement” provisions. We urge the Administration to work with the Office of the Inspector General and the U.S. Department of Justice to issue more formal guidance to provide security and continuity to practices when it comes to the “non-enforcement” provisions.
While emergency medicine professionals and facilities stand ready to help meet the needs of the American health system, we urge the Administration to make key policy changes using all available authorities to support the ability of emergency providers to provide services via telehealth or remote patient services where necessary:

(1) **EDPMA urges the Administration to add the emergency department (ED) evaluation & management (E/M) code set (CPT 99281-99285) to the list of telemedicine services (as listed at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes).** First, we believe that this would reduce confusion and quickly facilitate the ability of patients to get the care that they need. Second, by allowing ED E/M services to be provided via telehealth, the Administration will thereby definitionally extend patient protections associated with emergency services, including state bans on balance billing for emergency services and the Prudent Layperson Standard. There are numerous media reports that commercial payers are already starting to take this step. As we understand it, Blue Cross Blue Shield plans across the country are moving in this direction. For a specific example, however, Blue Cross Blue Shield of North Carolina has authorized the use of the ED E/M code set for telemedicine services (https://www.bluecrossnc.com/provider-news/covid-19-additional-details-about-relief-efforts) As noted above, CMS has suggested utilization of the outpatient and outpatient E/M codes even for telehealth services provided by emergency medicine providers. Claims submitted utilizing these codes will be processed according to in- and out-of-network provisions by the private payers and result in undue co-insurance and deductible costs for patients, provisions not triggered when the claim for service is under the emergency department codes listed above. Finally, CMS will ensure that the resources that are used in the emergency department to provide the services here under consideration are reflected in the codes that are being submitted.

(2) **EDPMA urges the Administration to issue a companion HCPCS code to G2012 that practitioners can use for new patients.** The Administration’s decision to not enforce the established patient requirement for telehealth services does not extend to G2012 given that G2012 is not a “telehealth” approved service, and therefore there is no policy that allows for claims submission of G2012 for new patients. We appreciate that in past rulemaking, CMS has taken action to provide coding and reimbursement for Medicare patients via a category of services referred to as Communication Technology-based services. We remind the Administration that these codes are not per se considered “telehealth” and therefore are not subject to the telehealth statutory and regulatory restrictions, and by extension, the waivers for those telehealth statutory and regulatory restrictions.

(3) **EDPMA urges the Administration to coordinate with commercial payers to ensure that emergency physicians that are enrolled Medicare providers are considered credentialed and able to provide all otherwise-approved telehealth

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1 G2012 (Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion).
services. We are extremely appreciative of the step that the Administration has already taken to waive the requirement that a physician or other health care professional be licensed in the State in which they provide a service. This will facilitate the provision of services via telehealth for Medicare patients while “allowing” physicians to provide services outside of the state in which they are licensed is important, we are concerned that this does not address any State licensure requirements, facility credentialing, or payers network requirements of facilities. Therefore, we are asking the Administration to use all due pressure to encourage systems and payers to accept a physician’s Medicare or Medicaid enrollment as sufficient criteria to deem the physician credentialed or in-network during the pandemic.

(4) **EDPMA urges the Administration to waive requirements that telehealth services can only be reported if the individual physician or health professional provided the service is not in the same location as the beneficiary.** In the CMS telehealth FAQs, the Administration states:

15. **Q: Should on-site visits conducted via video or through a window in the clinic suite be reported as telehealth services?**

A: Services should only be reported as telehealth services when the individual physician or professional providing the telehealth service is not at the same location as the beneficiary.

As the expected surge in cases and suspected cases comes toward us, we are expecting shortages in PPE and must ensure that our health care workers stay healthy and able to provide care to patients. In many cases, this will require the physician to provide telehealth services to patients in the same hospital or on the same grounds. We urge the Administration to remedy this as soon as possible so we can preserve PPE and protect our health care providers.

For this reason and others, Washington State recently requested several telehealth waivers, which we fully support. Again, rather than have States rely upon ad hoc waivers, we urge you to

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2 HIPAA security requirements (6.2) -- HIPAA Security Requirements. 45 C.F.R. 164.312(e)(1) – Transmission Security; Waive the security requirements for video communication in a telehealth visit. While CMS has lifted many of the patient site requirements to allow telehealth in the home as well as non-rural areas, many facilities are not prepared with secure platforms that they own and control which are also accessible to the patient. The request is to allow providers to use readily available platforms like Facetime, WhatsApp, Skype, etc. to facilitate the telehealth visit with the patient at home.

Telehealth 42 C.F.R. §410.78(b):

7.1 Consistent with the authority granted the Secretary under the Coronavirus Preparedness and Response Supplemental Appropriations Act, eliminate Medicare restrictions on licensing for telehealth and geographic restrictions on originating sites. Allow billing using CPT codes 99444 and 98969 for both new and established patients. Ask the HHS OIG to confirm that telemedicine screenings without co-pays and deductibles do not violate the CMP law or anti-kickback statute.

7.2 Eliminate the requirement that in order to bill for a telehealth service a provider must have billed that Medicaid or Medicare enrollee for a service within the previous three years.
formulate more comprehensive blanket waivers to address these key concerns. In addition, while
the changes that have been made to covered Telehealth services in the Medicare programs are
welcome, we urge you to ensure that these changes are comprehensively adopted across all
payers.

**Independent Free-standing Emergency Centers**
Independent free-standing emergency centers (IFEC) are owned, in whole or in part, by
independent groups or individuals and are not directly owned by a hospital. As such, they are
not licensed as a Hospital Outpatient Department and not recognized by CMS as eligible
for Medicare or Medicaid payment for the technical component of services provided in
IFECs. During a pandemic or natural disaster, all hospital-based emergency departments will be
overwhelmed and unable to care for, not only the patients suffering from the pandemic, but also
all the other patients having non-pandemic life threatening conditions. IFECs are fully equipped
emergency departments staffed by Emergency Medicine trained physicians. During this time, all
local resources should be available to patients, including IFECs, especially given that many of
those facilities may have key healthcare resources (e.g., respirators, isolation rooms) to assist in
caring for the patient overflow from hospital emergency departments. Therefore, we urge CMS
to include a blanket waiver to allow for IFECs to receive full Medicare and Medicaid
payments for both facility and professional services for all emergency care provided during the
pandemic.

**Surprise Insurance Gaps**
To ensure an appropriate public health response, individuals who may have COVID-19 should
not have unnecessary barriers to testing and subsequent care. Unfortunately, despite Congress’
recent efforts with House passage of the *Family First Coronavirus First Response Act* (H.R.
6201), significant insurance gaps will likely remain, as it relates to three key components – (1)
coverage of the COVID-19 test; (2) coverage of other tests or procedures at the same time of the
COVID-19 test; (3) coverage of professional services when the COVID-19 test is not available
or not appropriate; and (3) subsequent care and treatment of patient. Of course, all of these
activities are also assuming appropriate enforcement of the Prudent Layperson (PLP) standard as
well as a broadening of its application, given the public health benefits of doing so.

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7.3 Allow E&M codes to be billed via telehealth or telephonic services even for first time patients.
7.4 These steps will allow providers to screen and treat significantly more patients, reduce risk to front line health
care providers, and assist in resolving the shortage of providers.
7.5 Allow for reimbursement for telephone visits at the same rate as telehealth video visits. For many cases the
video aspect does not add value to the patient interaction – it’s the information relayed to the patient that
matters. See CPT codes 99441, 99442, 99443; HCPCS G2012, G0071. The state believes we have authority to do
this for telehealth and telephonic services under the Medicaid program, but this provision must be clarified for
Medicare. In addition, consistent with our request above for the codes to be opened for new patients in addition
to the established patients, which these codes currently only apply.
7.6 Allow capacity funding for providers, which may include grants or other funding Medicaid financing or other
dollars available to be used for purchase of equipment as necessary for providers and patients (e.g. laptops,
additional cell-phones or additional cell-phone plan minutes for clients so they are free to use the phone for
services).
7.7 Provide indemnify/hold harmless for emergency telehealth services.
Coverage of the COVID-19 test

Given the value of individuals receiving the COVID-19 test, there have been several initiatives to address this key topic. According to the Commonwealth Fund, fourteen states so far have taken action to prevent insurers from imposing cost sharing for coronavirus tests. Meanwhile, a number of major health insurers, including Aetna, Anthem, and 36 Blue Cross Blue Shield plans, have already announced they plan to cover coronavirus testing with no cost-sharing. Insurers, however, have balked at requiring so-called self-insured businesses (i.e., ERISA plans) from covering coronavirus testing with no copay. A number of insurers, including Aetna, Humana, and a number of Blues plans have allowed self-insured plans to opt-out of waiving cost sharing, according to a running tally compiled by the insurance lobby, AHIP. In addition, CMS has issued information regarding the coverage of such testing in Medicare and Medicaid, while also suggesting that the testing should be covered by health plans by explicitly clarifying that such testing should be an Essential Health Benefit (EHB).

Recently, House-passed Family First Coronavirus First Response Act (H.R. 6201) included several provisions to eliminate the cost-sharing for the COVID-19 test and resultant professional services, including providing coverage for uninsured individuals by allowing them to be added to Medicaid with a 100% FMAP and provisions to ensure that the professional services related to the administration of the test were also covered. However, the House-passed bill still will likely result in surprise insurance gaps for COVID-19, given that the language limits such coverage of the test to those with an Emergency Use Authorization (EUA) while the Food and Drug Administration (FDA) released a new final guidance document on March 16 which would expand testing beyond those with an EUA to additional tests, including (1) those approved by individual States and (2) additional flexibility while the EUA is being obtained (up to 14 days of testing). In light of the disconnect between the bill language and the FDA guidance and that neither emergency room doctors nor patients will likely know the regulatory status of any given test (i.e., is the EUA approved on the day the test was administered), this will likely result in surprise insurance gaps.

Coverage of Other Tests or Procedures

While it is important to ensure that patients have access to COVID-19 testing without cost-sharing, it is unlikely that COVID-19 testing will be the only test or panel required to make a full diagnosis. Therefore, it is imperative that policymakers fully recognize the additional testing. Otherwise, patients may learn of surprise gaps in their coverage, especially when the media portrays that initial visit as “no charge.”

Coverage of Professional Services when COVID-19 Test is Unavailable

So far, the reimbursement for the COVID-19 test assumes that such a test is available, or is appropriate, when the patient presents for care. Unfortunately, several States have reported delays in access to the test. Or, alternatively, even if a test is available, the patient may request the visit due two COVID-19 concerns, but, after examination of the provider and as a result of the professional opinion of the provider, such a test is not warranted. In the meantime, health care providers are still assessing patients to determine whether they are at risk for COVID-19. To ensure that patients do not experience a surprise insurance gap for these encounters, there should be explicit coverage of any services related to a suspected case of COVID-19, without cost-sharing.
Subsequent Care and Treatment
Perhaps the largest potential for a surprise insurance gaps is the subsequent care and treatment for COVID-19. AHIP has noted in its frequently asked questions (FAQs) this key statement:

*Health insurance providers continue to cover medically necessary health care costs to treat infectious diseases, including COVID-19, based on the terms of an individual’s insurance plan. At this time, there is no specific antiviral treatment or vaccine for COVID-19. People should receive care from their doctor to help relieve symptoms as they would other viral respiratory infections* (emphasis added).

Therefore, we support efforts to ensure subsequent coverage of care, as Washington State recently acknowledged in its waiver request.3

Beyond Prudent Layperson
Now, more than ever, the importance of the Prudent Layperson (PLP) Standard4 cannot be understated. Moreover, in light of the public health benefit for quickly recognizing those who may be infected with COVID-19, the standard for coverage should not simply rely on the person recognizing a “serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part,” but a larger risk to the broader community. For instance, while a thirty year old male may not have any risk factors to put him at risk of death (at least according to the latest information), to help protect his elderly grandparent with multiple co-morbidities who resides in his home, he should appropriately seek a COVID-19 test if displaying any of the key symptoms, even if he himself is not a great emergency risk. And, that visit should be fully covered, with no cost-sharing. Further, we urge the Administration to remain vigilant to ensure that insurers do not opt to retroactively decline coverage of COVID-19 testing, simply because the test result was negative.

Other Funding & Policy Needs
In these unprecedented times, we recognize that there will likely be additional funding needs for hospitals and providers. As you craft appropriate responses, we urge you to take into account those key needs and address them as necessary.

Extension of MIPS 2019 Filing Deadlines
As personnel are rushing to make changes and accommodate the clinical and logistical necessities related to COVID-19, practices are under a tremendous burden and are being stretched to their limits. Coincidentally, we are rapidly approaching the calendar year (CY) 2019 data submission deadline for the Merit-based Incentive Payment System (MIPS), which is March

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3 Treatment (8.10) Waive requirement that Washington State must submit and receive CMS approval of a Title XIX or Title XX state plan amendment in order to temporarily waive any patient cost sharing associated with COVID-9 screening, testing, and treatment. (emphasis added)

4 A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
31, 2020. Offices are currently focused on meeting the immediate needs of patients and attempting to quickly re-accommodate work flows and processes and are therefore are in need of additional time to submit all of the necessary information in order to meet the 2019 MIPS reporting requirements.

On March 13th, Secretary Azar, under Section 1135 waiver authority, officially announced:

> I also hereby modify deadlines and timetables and for the performance of required activities, but only to the extent necessary, as determined by the Centers for Medicare & Medicaid Services, to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the Medicare, Medicaid and CHIP programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of these requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse.

Under this provision, EDPMA urges CMS to extend the MIPS 2019 filing deadline from March 31, 2019 until at least June 30, 2020. While we appreciate the waiver language, it still requires CMS to follow-up and clearly articulate which deadlines and requirements are moved or suspended. It is imperative that CMS release this information as quickly as possible giving the impending deadline so that practices are able to focus on the crisis and the issues of most immediate need.

Sincerely,

Bing Pao, MD, FACEP
Chair of the Board, EDPMA

CC:
Speaker of the House of Representatives Nancy Pelosi
Senate Majority Leader Mitch McConnell
Senate Minority Leader Chuck Schumer
House Minority Leader Kevin McCarthy