American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

March 13, 2020

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

Dear Secretary Azar:

On behalf of our 38,000 members, the American College of Emergency Physicians (ACEP) wants to thank you for your continued efforts to respond to the novel coronavirus (COVID-19). As you know, it is critical to ensure that our nation's emergency physicians and health care system have the resources they need to treat patients in response to what is now a global pandemic.

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The situation on the ground is constantly changing, and the Trump Administration has continued to provide information about the disease to patients, health care professionals, health plans, and other stakeholders as new evidence and data become available, releasing new or revised guidance, fact sheets, and answers to frequently asked questions (FAQs). ACEP has carefully tracked the numerous actions the Administration has taken and has worked to update our members and the patients we serve with critical information.

While ACEP appreciates the information and guidance the Administration has released thus far, we have identified some key gaps that, if addressed, could help provide the clarity and flexibility that will be necessary to protect both patients and front-line health care workers in the challenging weeks that lie ahead. These major gaps include:

- Expanding the Number of Available Tests Across the Country;
- Coverage and Full Elimination of Cost-Sharing of Testing and Services Related to the Treatment of COVID-19;
- Coverage and Reimbursement of Emergency Telehealth Services;
- Appropriate Liability Protections for Front-line Health Care Workers;
- Clarification of the Centers for Disease Control and Prevention (CDC) Guidance on the Quarantining of Health Care Professionals Exposed to COVID-19;
- Guidance to Patients on When it is Appropriate to Come to the Emergency Department; and
- A Thirty-day Delay of All Regulatory Requirements and Deadlines for Medicare Health Care Professionals.

Expand the Number of Available Tests Across the Country

Despite the Administration's efforts, most emergency departments (EDs), hospitals, doctors' offices, and other urgent care and outpatient clinics across the country are facing a severe shortage in the number of COVID-19 tests. Broader testing not only increases the likelihood that treatment can be provided early (when it has been found to be more effective), but it also helps ensure those with mild or even no symptoms to know they must now isolate themselves until they recover, limiting further spread in the community. As well, it provides public health officials with valuable information with which to track the virus's spread and identify areas where additional resources might be needed.

We are encouraged by today's announcement to make ADM. Brett Giroir in charge of coordinating testing efforts across the public and private sectors, and we hope that the supply of tests will dramatically increase.

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

As we work together 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 related to COVID-19. The Centers for Medicare & Medicaid Services (CMS) has put out guidance for patients with Traditional Medicare, Medicare Advantage or Medicare Part D prescription drug coverage, who are enrolled in Medicaid and CHIP, and who are enrolled in non-grandfathered private health plans in the individual and small group markets, including qualified health plans purchased on the Exchange. Most recently, CMS released a set of FAQs clarifying how COVID-19 coverage falls under the essential health benefits (EHBs) that are mandated for many private health plans. In the document, CMS states that "many health plans have publicly announced that COVID-19 diagnostic tests are covered benefits and will be waiving any cost-sharing that would otherwise apply to the test. Furthermore, many states are encouraging their issuers to cover a variety of COVID-19 related services, including testing and treatment, without cost-sharing, while several states have announced that health plans in the state must cover the diagnostic testing of COVID-19 without cost-sharing and waive any prior authorization requirements for such testing."

While ACEP appreciates that cost-sharing will be waived for COVID-19 tests, it remains unclear whether this extends beyond copayments to also include coinsurances and deductibles in covering all the diagnostic and treatment services for patients with suspected or confirmed cases of COVID-19. It is more often coinsurances and deductibles that put a financial strain on patients rather than copayments, and therefore it is important for them to be included in this cost-sharing waiver. We urge the Administration to require all health plans to waive cost-sharing (including copayments, coinsurance, and deductibles) for all office, outpatient, and ED visits that result in an order for or administration of COVID-19 tests. To be clear, patients' cost-sharing should be waived for *all* services in the visit, even if the COVID-19 test comes in negative. Insurers should not be allowed to retroactively deny claims or not cover cost-sharing if patients thought that they may have the disease but wound up not having it.

Further, now more than ever, the Administration must enforce the prudent layperson standard (PLP) standard. This important patient protection states that payers must cover any medical condition "manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1) placing the health of the individual (or a pregnant woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions, or 3) serious dysfunction of any bodily organ or part." First established under the Balanced Budget Act of 1997, the PLP originally applied to all of Medicare and to Medicaid managed care plans, and then was extended under the ACA to all insurance plans regulated under the Employee Retirement Income Security Act of 1974 (ERISA) and qualified health plans in the state Exchanges. Furthermore, 47 states (all except Mississippi,

New Hampshire, and Wyoming) have passed their own laws making some kind of prudent layperson standard mandatory in their state.

Removing the fear of potential out-of-pocket costs will remove what could be a dangerous obstacle to more widespread testing and resulting containment.

Coverage and Reimbursement of Emergency Telehealth Services

The ability to provide telehealth services to patients with suspected cases of COVID-19 is becoming even more critical as the volume of patients with flu-like symptoms increases. Similar to the guidance CMS put out on COVID-19 coverage described above, CMS has tried to explain how telehealth services are covered and reimbursed under Medicare, Medicaid and CHIP, and private health plans. While we understand that CMS is limited in Medicare under the restrictions imposed by Section 1834(m) of the Social Security Act (SSA), we strongly urge CMS and HHS to use their waiver authorities under today's Presidential emergency declaration to expand the coverage and reimbursement of emergency telehealth services. We also urge the Administration to release guidance that addresses some of the current regulatory and legal barriers to providing telehealth services. In all, our specific requests include:

- **Add emergency services codes to the list of approved Medicare telehealth codes:** ACEP would like some clarification that the HHS Secretary's waiver authority includes the ability to add new codes to the list of approved telehealth services without going through the rulemaking process. Specifically, we request that the five ED evaluation and management (E/M) codes as well as the ED observation codes be added to the list of approved Medicare telehealth services. We also want to ensure that the originating site requirements and other restrictions are waived for emergency telehealth services. That way, hospitals can establish telehealth programs where they can have emergency physicians in the ED treating patients from their homes via telehealth—thereby avoiding potential overcrowding of the ED, preventing contamination of other patients, and reducing the amount of personal protective equipment (PPE) that health care workers use. Currently, hospitals are trying to develop telehealth protocols and programs without clear guidance and without consistent, ongoing funding or reimbursement mechanisms.

- **Waive the originating site requirement and geographic limitation:** CMS should waive the originating site and geographic restrictions for all telehealth services under Medicare, allowing telehealth services to be provided in any location (including a patient's home) and in both urban and rural areas.

- **Clarify applicability of the Emergency Medical Treatment and Labor Act (EMTALA) for telehealth medical screening exams:** We would like clarification on whether a medical screening exam (as defined by EMTALA) can be provided via telehealth. While appreciated, the EMTALA guidance that was recently released does not address telehealth.

- **Relax credentialing/licensure barriers:** Currently, there are some credentialing and licensing barriers that are preventing emergency telehealth programs from being stood up. For example, some hospitals require health care professionals wishing to provide telehealth services to wait 90 days to be credentialed—this timeline obviously does not work in this situation. Further, health care professionals who wish to provide telehealth services across state lines should be temporarily waived from certain state licensing requirements. Overall, guidance relaxing current licensing and credentialing requirements for providing telehealth services is critical.

- **Encourage quarantined but asymptomatic physicians to provide telehealth services:** CMS should consider issuing guidance that encourages health care professionals who are forced to self-quarantine but remain asymptomatic to provide telehealth services. Some areas of the country may very soon be facing significant shortages of emergency physicians and other frontline personnel as they become exposed and must be quarantined.

Appropriate Liability Protections for Front-line Health Care Workers

As emergency physicians, we have a moral, ethical, and legal responsibility to treat every patient who comes to the ED regardless of their ability to pay—and we strongly support the patient protections embedded in EMTALA. However, for the duration of this crisis we request that HHS temporarily make some necessary modifications to EMTALA to provide front-line workers with the flexibility they will need to be able to appropriately treat and keep up with what may soon be an unprecedented surge of patients. With the President's declaration of an emergency under the Stafford Act and your own declaration of a Public Health Emergency on January 31, you now have the authority to issue EMTALA waivers. We therefore request that you waive certain elements of EMTALA to allow for more flexibility in meeting the current medical screening exam (MSE) and stabilization requirements. Specifically, as mentioned above, physicians and other qualified health professionals should be able to provide MSEs to patients via telehealth. Further, CMS should explore other ways that MSEs can be provided to patients in alternative locations, including drive-through clinics, that can possibly reduce exposure to the disease.

In addition, many hospitals have developed crisis standards to prepare for scenarios where health care professionals are forced to make extremely difficult choices about individual patients and available resources. A pandemic or other disaster will strain medical resources and thereby may require a shift in care that was previously focused on the individual patient to that which is focused on doing the most good for the greatest number. Health care resources include, but are not limited to, personnel, supplies, hospital beds and space, medications, and treatment. Rather than doing everything possible to try to save every life; in a disaster, it will be necessary to allocate scarce resources to save as many lives as possible. The Administration must review and consider various such scenarios where health care professionals should be held free from liability during this crisis. You recently provided liability immunity to manufacturers, distributors, certain healthcare providers, and other entities in relation to covered countermeasures, except in cases of willful misconduct; extending similar immunity temporarily to emergency physicians and other frontline personnel will ensure greater flexibility and capacity to treat more patients.

Clarification of the Centers for Disease Control and Prevention (CDC) Guidance on the Quarantining of Health Care Professionals Exposed to COVID-19

The CDC has issued guidance on when health care professionals who have been exposed to individuals with COVID-19 should self-quarantine for a 14-day period. While we appreciate that the CDC has recently modified the guidance to allow asymptomatic health care professionals "who have had an exposure to a COVID-19 patient to continue to work after options to improve staffing have been exhausted," ACEP remains concerned that as certain areas of the country become overwhelmed with COVID-19 patients, the guideline will be impossible to operationalize without the majority of health care professionals being required to stay home. In these cases, which could quickly become common, it will be extremely difficult to ensure that hospitals and EDs are sufficiently staffed to serve the influx of patients. Even now, we are hearing from EDs that they are setting aside already scarce tests so that they can conduct repeat tests on exposed personnel in order to be able to bring them back to work faster.

We urge the CDC to continue to revise their guidance and for the Administration in general to promote alternative methods, such as telehealth, for exposed health care professionals to still serve their patients.

Guidance to Patients on When it is Appropriate to Come to the Emergency Department

ACEP is extremely concerned that the Administration has not clearly communicated to patients when they should go to the ED. While we strongly believe that patients who believe that they are experiencing an emergency have every right to come to the ED and be fully covered for that visit by their insurer, in this time of great anxiety and uncertainty, some individuals without potentially life-threatening symptoms may still feel compelled to go the ED to get tested. As the number of COVID-19 cases increases, we need to keep space open in EDs to treat patients with serious conditions. Overcrowding of the ED can significantly slow down our ability to treat critically ill patients and will further expose patients and health care workers to the disease.

CMS' messaging around ED visits has especially been an issue. For example, the title of the press release announcing the EMTALA guidance is "CMS Issues Call to Action for Hospital Emergency Departments to Screen Patients for Coronavirus." Someone reading the press release would immediately think that the best, and potentially only, place to get a test is the ED, even when they are not experiencing any symptoms and are concerned only by a potential exposure to an infected patient. These misleading messages could have broad-scale ramifications as EDs have limited resources to treat patients with COVID-19.

In all, we request that both the CDC and CMS put out patient-facing guidance that helps patients understand when it is appropriate to go to the ED. ACEP has released our own guidance and materials for patients, which we urge the Administration to use as a template.

A Thirty-day Delay of All Regulatory Requirements and Deadlines for Medicare Health Care Professionals

As emergency physicians and other health care professionals are spending all their time and attention dealing with this crisis, they do not have the capacity to meet the specific regulatory requirements, including their reporting obligations, under CMS' quality performance programs. The major reporting program for physicians in Medicare is the Merit-based Incentive Payment System (MIPS). Physicians currently have to submit their data for the calendar year (CY) 2019 performance period by March 31st. CMS should extend this deadline and other similar regulatory deadlines by at least 30 days so that emergency physicians and other health care professionals can keep all their focus on treating patients. This type of flexibility is consistent with the administrative relief the Office of Management and Budget (OMB) issued to recipients and applicants of federal financial assistance.

We appreciate the opportunity to share our comments. As emergency physicians are on the front lines of this pandemic, ACEP is willing and eager to work with you and we stand ready to be a resource to the Administration and to all patients during this challenging time. If you have any questions, please contact Laura Wooster, ACEP's Associate Executive Director of Public Affairs at lwooster@acep.org.

Sincerely,

William P. Jaquis, MD, MSHQS, FACEP

ACEP President