

April 21, 2020

The Honorable Alex M. Azar II
Secretary
U.S. Department of Health & Human Services
200 Independence Avenue SW
Washington, DC 20201

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
P.O. Box 8013
Baltimore, MD 21244

Dear Secretary Azar and Administrator Verma:

The 22 undersigned organizations applaud the expeditious actions by the U.S. Department of Health & Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) to issue waivers and new rules that help healthcare professionals and facilities adapt to the needs of the coronavirus pandemic. We thank the Administration for the regulatory flexibilities provided thus far to support surgeons during this national public health emergency (PHE) to deliver safe, high-quality care to their patients and to assist their communities in mitigating the spread of COVID-19. We offer feedback for consideration by HHS and CMS as the Administration explores additional steps to ensure that physicians and hospitals are equipped to effectively absorb and manage potential surges of critically ill individuals during this time of crisis.

The following is a summary of the recommendations in this letter:

Telehealth and Other Non-Face-to-Face Services:

- Align dates for all policies expanding telehealth benefits during the PHE to become retroactively effective on March 1, 2020
- Allow office/outpatient evaluation and management codes to be billed as telehealth services even if such services are delivered via audio only
- Establish corresponding G-codes that describe new patient encounters for communication technology-based services with code descriptors referring specifically to “established patients”

Accelerated and Advance Payments Program

- Extend the repayment timeframe of “all other Part A providers and Part B suppliers” to match the one-year repayment timeframe of inpatient acute care hospitals, children’s hospitals, certain cancer hospitals, and critical access hospitals

Prior Authorization

- Suspend prior authorization and other utilization management requirements under the Medicare fee-for-service, Medicare Advantage, and Part D programs for the duration of the PHE

Global Surgery Data Collection

- Waive the requirement to report Current Procedural Terminology (CPT) code 99024 for the duration of the PHE
- Refrain from using data collected during the PHE for purposes of analyzing the number of postoperative visits provided with 10- and 90-day global codes

Preoperative History and Physical Requirements

- Waive the hospital Medicare Condition of Participation for inpatient elective procedures during the PHE to reduce administrative burden and enable physicians to exercise their own medical decision-making to determine when such an examination should be completed

Personal Protective Equipment/Essential Medical Equipment Distribution and Access

- Coordinate with the Federal Emergency Management Agency (FEMA), the White House, and other agencies to streamline the personal protective equipment (PPE) distribution process, create a centralized equipment coordination unit, and share distribution data for PPE

Public Health and Social Services Emergency Fund

- Provide additional support and immediate relief to providers when determining the disbursement of the remaining portion of the fund to ensure that a sufficient clinical workforce is available in this country now, throughout the pandemic, and after the pandemic subsides

More information about these recommendations is described in detail below.

TELEHEALTH

To facilitate the use of telecommunications technology as a safe substitute for in-person care, CMS has, on an interim basis, broadened its list of covered Medicare telehealth services, eliminated site-of-service, frequency, and other requirements associated with particular services furnished via telehealth, and clarified several payment rules applicable to other services, such as emergency department visits, initial nursing facility and discharge visits, home visits, and therapy services, that can be furnished using telecommunications technologies to reduce COVID-19 exposure risks.

Alignment of Effective Dates

We thank CMS for expanding telehealth benefits under its 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations (CARES) Act on March 17, 2020, as well as through the Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency interim final rule with comment (IFC), published in the *Federal Register* on April 6, 2020.^{1,2} Currently, the telehealth waivers issued on March 17 apply to services furnished on or after March 6, 2020, while the regulations included in the IFC are applicable beginning March 1, 2020. **For consistency within these temporary Medicare telehealth billing guidelines, we request that all such policies become retroactively effective on March 1, 2020.**

Audio-Only E/Ms

As part of its March 17 announcement, CMS waived certain requirements related to the Medicare telehealth benefit. On a temporary and emergency basis, Medicare will pay for telehealth services provided to patients located anywhere in the country, including in a patient's place of residence. Given that office and outpatient evaluation and management (E/M) services are already on the list of approved Medicare telehealth services, such changes also apply to those code sets. However, the Agency requires these services be provided using both audio and video telecommunications technology and does not make an exception for visits for which video is not available.

We appreciate this added flexibility the Agency has provided regarding the provision of telehealth services during the PHE. **However, we are concerned that, in many cases with respect to delivering an office/outpatient E/M service, the video component of the billing requirements will be a challenge for both patients and physicians.** Unfortunately, some patients, especially those who are

¹ Centers for Medicare & Medicaid Services. (2020). Medicare telemedicine health care provider fact sheet [Press release]. Retrieved from <https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet>

² Centers for Medicare & Medicaid Services. (2020). *Medicare and Medicaid programs; Policy and regulatory revisions in response to the COVID-19 public health emergency*. Retrieved from <https://www.cms.gov/files/document/covid-final-ifc.pdf>

elderly or in rural areas and who would benefit the most from reduced exposure to COVID-19, only have telephones with audio capabilities, or are unable to easily use video communication due to lack of understanding of the technology, connectivity problems, and/or troubleshooting difficulties. Moreover, many providers did not use telehealth prior to the COVID-related telehealth waivers, so they did not have the necessary tools in place to render such services before the coronavirus outbreak. Therefore, essential telecommunications equipment such as webcams and headsets are back-ordered—and thereby inaccessible to—providers and hospitals as they rapidly work to establish audiovisual alternatives to in-person care.

Additionally, we believe that CMS' allowance of documentation for E/Ms delivered via telehealth using either medical decision-making *or* time, as well as the Agency's elimination of the history and physical exam requirement for office/outpatient E/Ms delivered via telehealth, during the pandemic make it easier to meet the requirements of providing an E/M service using audio alone. **Therefore, we ask that during the PHE, CMS provide additional leniency for the underlying technology required to furnish E/M services, and urge the Agency to allow office/outpatient E/Ms (CPT codes 99201-99205 and 99211-99215) to be billed as a telehealth service, even if the service is delivered via audio only.**

Alternatively, we encourage CMS to provide, on a temporary basis, payment parity between telehealth E/M codes and telephone E/M codes (99441-99443) by increasing the relative value units (RVUs) of CPT codes 99441-99443 to equal those of CPT codes 99212-99214.

OTHER NON-FACE-TO-FACE SERVICES

Extension of Coverage for Communication Technology-Based Services to New Patients

In its IFC, CMS indicated that it does not believe that limiting the provision of telecommunications technology services to established patients only is warranted during the PHE. While some of the code descriptors for covered communication technology-based services refer to "established patients," the Agency stated that it will exercise discretion on an interim basis to relax enforcement of this aspect of the code descriptors and will not conduct reviews to determine whether those services were furnished to established patients. Therefore, CMS intends to allow such services to be furnished to both new and established patients, regardless of the language included in the code descriptor.

We thank CMS for extending coverage and payment for communication technology-based services to new patients. Still, we remain concerned that, although the Agency will not perform claims audits to assess whether the furnishing physician had an existing relationship with the patient to whom a service was rendered using telecommunications technology, the current "established patient" terminology within the description of numerous communication technology-based codes run contrary to CMS' interim guidance and may complicate or confuse documentation processes for physicians and billing staff. **Because it is neither standard nor intuitive for physicians to select codes with descriptors that do not accurately reflect the services they provided, we urge the Agency to create temporary "new patient" G-codes that mirror their "established patient" code counterparts.**

Specifically, we request that CMS establish corresponding G-codes that describe new patient encounters for the following CPT and Healthcare Common Procedure Coding System (HCPCS) codes:

- **Online Digital Evaluation and Management (E/M) Services, including those Furnished by Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs):**
 - CPT code 99421 (*Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes*)
 - CPT code 99422 (*Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes*)

- CPT code 99423 (*Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes*)
 - HCPSCS code G2062 (*Qualified nonphysician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 11– 20 minutes*)
 - HCPSCS code G2063 (*Qualified nonphysician qualified healthcare professional assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes*)
- **Telephone E/M Services:**
 - CPT code 99441 (*Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian 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*)
 - CPT code 99442 (*Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian 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; 11-20 minutes of medical discussion*)
 - CPT code 99443 (*Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian 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; 21-30 minutes of medical discussion*)
 - CPT code 98966 (*Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion*)
 - CPT code 98967 (*Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion*)
 - CPT 98968 (*Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion*)
- **Communication Technology-Based Services:**
 - HCPSCS code G2010 (*Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, 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*)
 - HCPSCS code 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*)

ACCELERATED AND ADVANCE PAYMENTS PROGRAM

On March 28, 2020, CMS announced an expansion of the Accelerated and Advance Payment Program to increase cash flow to providers of services and suppliers impacted by the COVID-19 pandemic.³ CMS has extended the repayment of these accelerated/advance payments to begin 120 days after the date of issuance of the payment. The repayment timeline is broken out by provider type below:

- Inpatient acute care hospitals, children's hospitals, certain cancer hospitals, and critical access hospitals (CAHs) have up to one year from the date the accelerated payment was made to repay the balance.
- All other Part A providers and Part B suppliers will have 210 days from the date of the accelerated or advance payment was made to repay the balance.

Medicare guidance states that the repayment will begin on day 120, and given that repayment is required by day 210, physicians will have a total of only 90 days to repay an accelerated or advance payment of up to three months of Medicare payments. For surgeons who are not doing elective surgeries, the recoupment process could start at a time when they are still facing COVID-related financial pressures. In addition, for Medicare Administrative Contractors (MACs) to recoup up to 100 percent of reimbursements within 90 days, the physician could be left with no Medicare revenue at all during the recoupment period, which is even more likely if, as expected, medical practice operations have not fully returned to normal within 210 days. **For these reasons, we ask that CMS extend the repayment timeframe of “all other Part A providers and Part B suppliers” to match the one-year repayment timeframe of inpatient acute care hospitals, children’s hospitals, certain cancer hospitals, and CAHs.** Of perhaps even greater concern are the interest rates that would be due on balances that have not been fully repaid within 210 days. While we understand that the interest rate applied to these balances is determined by statute, it is all the more imperative that CMS provide a longer repayment timeframe given that balances after the due date will be subject to an interest rate currently set at 10.25 percent.

PRIOR AUTHORIZATION

In a March 10, 2020, memorandum to Medicare Advantage Organizations (MAOs) and Part D plan sponsors, CMS indicated that such plans may *choose* to waive prior authorization (PA) requirements that otherwise would apply to tests, services, or drugs used to diagnose, treat, or prevent COVID-19.⁴ However, given the scope and severity of the current PHE and its impact on clinical practice, we believe that more action from the Agency is needed to lessen the extraordinary administrative burden PA and other utilization management practices place on physicians and their practices.

Complying with PA requirements imposed by MAOs, Part D plan sponsors, and other payors consumes considerable resources and further delays treatment at a time when many practices are overworked and operating with significantly reduced staff. Under these circumstances, we believe that dedicating precious physician, nursing, and administrative staff time to the task of seeking PA for medically necessary services is an extreme detriment to patient safety and continuity of care.

We are aware that CMS has granted waivers to numerous state Medicaid plans to suspend

³ Centers for Medicare & Medicaid Services. (2020). Trump Administration provides financial relief for Medicare providers [Press release]. Retrieved from <https://www.cms.gov/newsroom/press-releases/trump-administration-provides-financial-relief-medicare-providers>

⁴ Centers for Medicare & Medicaid Services. (2019). *Information related to coronavirus disease 2019—COVID-19*. Retrieved from <https://www.cms.gov/files/document/hpms-memo-covid-information-plans.pdf>

PA requirements and to extend pre-existing authorizations for a Medicaid beneficiary who has previously received PA during the COVID-19 pandemic. We believe that similar action by MAOs and Part D plan sponsors has the potential to increase timely access to care and facilitate deployment of physicians and other clinical staff to more urgent tasks. **For this reason, we urge CMS to instruct MAOs and Part D plan sponsors to suspend PA and other utilization management requirements, such as step therapy, for the duration of the coronavirus PHE. We also ask the Agency to waive all PA rules under the Medicare fee-for-service program for the remainder of the national emergency.**

GLOBAL SURGERY DATA COLLECTION

As required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), CMS implemented a process for collecting data on the number and level of postoperative visits related to 10- and 90-day global codes. Beginning July 1, 2017, CMS required practitioners in groups of 10 or more, practicing in nine specified states, to report CPT code 99024 (*Postoperative follow-up visit*) for each postoperative visit after select procedures with 10- and 90-day global periods in order to collect data on the number of postoperative visits that were provided associated with those global services. The value of reporting code CPT 99024 is contingent upon accurate data collection; however, surgeons and other clinicians are currently focusing their time, staff, and other resources on addressing and limiting the spread of COVID-19 in their communities. With their attention diverted to addressing this crisis, surgeons and others should not be required to report CPT code 99024, as all efforts should be exclusively focused on meeting today's most urgent needs. **As such, given the numerous pressures on physicians and other clinicians at this time, we ask that CMS waive the requirement to report CPT code 99024 for the duration of the PHE and not use data collected at this time for purposes of analyzing the number of postoperative visits provided.**

PREOPERATIVE HISTORY & PHYSICAL REQUIREMENTS

CMS develops and maintains Conditions of Participation (CoPs) that health care organizations must meet in order to begin and continue participating in the Medicare program. Current CMS CoPs for hospitals require that such facilities have a set of medical staff bylaws that must include a requirement that a history and physical (H&P) examination be completed and documented for each patient no more than 30 days before or 24 hours after admission, but prior to surgery or a procedure requiring anesthesia services. The bylaws must also include a requirement that an updated examination of the patient is completed and documented within 24 hours after admission or registration, but prior to a procedure utilizing anesthesia services, when the H&P is completed within 30 days before admission.⁵

As hospitals and surgeons work together to implement CMS' recommendations to limit all non-essential planned medical, surgical, and dental procedures during the COVID-19 outbreak, additional regulatory relief is needed to ease certain preoperative service requirements, including the 30-day H&P CoP. We are strongly concerned that the specification of any short time period for the acceptability of preoperative evaluations (i.e., no more than 30 days before or 24 hours after admission) is unreasonable and adds barriers to the delivery of timely care; for example, under the current CoP, an elective procedure scheduled for the 31st day after an H&P was performed would trigger the need for a duplicative examination and related laboratory or imaging tests, further delaying needed surgical services and potentially shifting more out-of-pocket costs onto patients. In addition, physicians are not reimbursed for the provision of a second H&P, which is bundled into the pre-service package despite the additional work required to repeat the examination in order to comply with the Agency's hospital CoP.

⁵ 42 CFR §482.22(c)(5)

We believe that allowing hospitals and surgeons the discretion to jointly establish preoperative policies for inpatient elective procedures—based on their clinical judgment, facility characteristics, and patient population served—is more practical than the current “one size fits all” 30-day H&P mandate and would reduce administrative and financial burdens for patients and physicians during this PHE. Moreover, we wish to highlight that CMS eliminated the same blanket H&P requirement for ambulatory surgical centers (ASCs) and hospital outpatient departments (HOPDs) in 2019, stating that a less burdensome option for the assessment of a patient prior to an ASC/HOPD surgery was warranted.⁶ **As such, we urge the Agency to waive this onerous and redundant H&P hospital CoP for inpatient elective procedures during the PHE to enable physicians to exercise their own medical decision-making to determine when an H&P examination should be completed, if appropriate, based on an individual patient’s history and clinical presentation, along with evidence-based standards for the delivery of safe and quality surgical care.**

PERSONAL PROTECTIVE EQUIPMENT AND ESSENTIAL MEDICAL EQUIPMENT DISTRIBUTION AND ACCESS

Health care facilities across the country are facing growing shortages of PPE, primarily face masks, gowns, and gloves. In addition, surgeons are reporting that the distribution of PPE, medical equipment such as critically needed ventilators, and other essential items is haphazard and inequitable. The Federal Government can play an important role in addressing PPE distribution problems during this time of crisis. **Specifically, we urge the Administration to coordinate with the FEMA, the White House, and other agencies to streamline the PPE distribution process, create a centralized equipment coordination unit, and share distribution data for PPE.** This information should be regularly updated to ensure that medical professionals and their staff can plan accordingly. Such coordination is essential for physicians and other clinicians at the frontlines of patient care across the nation who are putting both their own well-being and that of their patients at risk as they work to save the lives of those infected with COVID-19.

We are also concerned with the supply chain and patient access to Extracorporeal Membrane Oxygenation (ECMO), which is a lifesaving support that becomes the last option for patients who are not successfully maintained on a ventilator. ECMO requires specialized supplies such as oxygenators and filters of which many facilities are critically low. We ask that the Administration facilitate production and distribution for ECMO, and also monitor ECMO access, best practices, and outcomes for this critical service.

Additionally, on April 3, 2020, the White House released the “Statement from the President Regarding the Defense Production Act,” which addresses hoarding, price gouging, and export of critically needed PPE.⁷ We urge the Administration to coordinate with the President’s Coronavirus Task Force in any way necessary to assist in implementing these or other measures to protect the supply of PPE.

PUBLIC HEALTH AND SOCIAL SERVICES EMERGENCY FUND

The \$100 billion added to the Public Health and Social Services Emergency Fund (PHSSEF) by the CARES Act is intended to afford relief to providers who are responding to the COVID-19 crisis, including physician practices who are suffering financial loss due to the PHE.⁸ Physician practices are facing a variety of hardships as they come together to fight the pandemic. The vast majority of surgeons

⁶ Centers for Medicare & Medicaid Services. (2019). *Medicare and Medicaid programs; Regulatory provisions to promote program efficiency, transparency, and burden reduction*. Retrieved from <https://www.govinfo.gov/content/pkg/FR-2019-09-30/pdf/2019-20736.pdf>

⁷ The White House, Office of the Press Secretary. (2020). *Statement from the President regarding the Defense Production Act*. Retrieved from <https://www.whitehouse.gov/briefings-statements/statement-president-regarding-defense-production-act-3/>

⁸ Coronavirus Preparedness and Response Supplemental Appropriations (CARES) Act, Title VIII, Division B

have complied with CMS guidelines to suspend elective surgery. Surgeons recognize that these steps are needed to preserve diminishing PPE and other medical supplies for treating patients with COVID-19 and to slow the community spread of the virus. Unfortunately, our members have informed us of reduced hours and furloughs resulting in diminished or minimal salaries. If a physician practice is forced to close due to financial hardship, it could have a devastating impact on access to care and the health of its community.

While cash flow restriction impacts all clinicians, small physician practices are particularly vulnerable as they have less access to capital and are already operating on thin margins. In addition, large physician practices and faculty practice plans that have over 500 employees might not qualify for the small business assistance under the CARES Act and could find themselves in the untenable position of laying off staff and physicians due to lower financial revenues.

Initial \$30 Billion of PHSSEF Expansion

We appreciate that HHS disbursed the first \$30 billion to both providers and hospitals starting on April 10, 2020. Providing support for all physicians who are experiencing revenue losses and non-reimbursable expenses as a result of the COVID-19 pandemic is just as critical to ensure the health and safety of Americans now and once the PHE is lifted. After recent changes, the Terms and Conditions for this emergency fund no longer require that a recipient of funds attest to “currently” taking care of possible or actual COVID-19 patients, but rather that the recipient did so after January 31, 2020:

The Recipient certifies that it billed Medicare in 2019; ***provides or provided after January 31, 2020 diagnoses, testing, or care for individuals with possible or actual cases of COVID-19;*** is not currently terminated from participation in Medicare; is not currently excluded from participation in Medicare, Medicaid, and other Federal health care programs; and does not currently have Medicare billing privileges revoked.⁹ (emphasis added)

In addition, recent changes to the HHS website related to this emergency fund include additional guidance indicating that HHS considers every patient as a possible case of COVID-19:

If you ceased operation as a result of the COVID-19 pandemic, you are still eligible to receive funds so long as you provided diagnoses, testing, or care for individuals with possible or actual cases of COVID-19. Care does not have to be specific to treating COVID-19. ***HHS broadly views every patient as a possible case of COVID-19.***¹⁰ (emphasis added)

However, the Terms and Conditions also state that “*(t)he Recipient certifies that the Payment will only be used to prevent, prepare for, and respond to coronavirus, and shall reimburse the Recipient only for health care related expenses or lost revenues that are attributable to coronavirus*” (emphasis added).¹¹ We seek more guidance on HHS’ interpretation of “prevent, prepare for, and respond” in this context. For surgeons who have had to suspend elective surgery due to COVID-19, we ask for clarification on the types of expenses that the PHSSEF payments could be used for. For example, would continuing to pay

⁹ Department of Health and Human Services. (2020) *Relief Fund Payment Terms and Conditions*. Retrieved from <https://www.hhs.gov/sites/default/files/relief-fund-payment-terms-and-conditions-04132020.pdf>

¹⁰ Department of Health and Human Services. (2020) *CARES Act Provider Relief Fund*. Retrieved from <https://www.hhs.gov/provider-relief/index.html>

¹¹ Department of Health and Human Services. (2020) *Relief Fund Payment Terms and Conditions*. Retrieved from <https://www.hhs.gov/sites/default/files/relief-fund-payment-terms-and-conditions-04132020.pdf>

furloughed employees meet this requirement? We also question whether the intent of this policy would be more directly reflected if the two instances of “and” in this section were replaced by “or.”

Taken together, we believe that these provisions, the press releases, fact sheets, and language of the CARES Act confirm that **all** physicians, including those that have suspended elective surgery, are intended Recipients of the PHSSEF initial \$30 billion disbursement. **However, given that Recipients are required to attest to the Terms and Conditions prior to submitting reports ensuring compliance, and that the reporting requirement are not yet described, we ask for further guidance on HHS’ interpretation of the “prevent, prepare for, and respond,” which is part of such Terms and Conditions.**

Remaining \$70 Billion of PHSSEF Expansion

For the remaining \$70 billion, we support the use of this funding for providers in areas particularly impacted by the COVID-19 outbreak, rural providers, providers of services with lower shares of Medicare reimbursement or who predominantly serve the Medicaid population, and providers requesting reimbursement for the treatment of uninsured Americans. In particular, some specialties, such as obstetrics and gynecology, may have many patients insured by Medicaid, but few or no patients insured by Medicare, and therefore might require a different approach. Focus on these areas alone, however, is not enough to ensure the viability of some practices that have already experienced layoffs, furloughs, and insufficient revenue to remain financially solvent. According to our calculations, physician services under the Medicare Physician Fee Schedule received approximately 15 percent of the first \$30 billion in funds dispersed on April 10, which represents only approximately 1/16 of their annual Medicare reimbursement. **We urge HHS to provide additional support and immediate relief to providers when determining the disbursement of the remaining portion of the fund to ensure that a sufficient clinical workforce is available in this country now, throughout the pandemic, and after the pandemic subsides.**

We appreciate HHS’ and CMS’ actions over the last few weeks to address the COVID-19 PHE and to afford flexibility to physicians as they fight this crisis on various levels. We ask that the Administration consider these additional recommendations to enhance steps already taken to support physicians as they work to provide the best possible care to their patients both now and in the future.

Sincerely,

American College of Surgeons
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Ophthalmology
American Academy of Otolaryngology – Head and Neck Surgery
American Society of Breast Surgeons
American Society of Cataract and Refractive Surgery
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Obstetricians and Gynecologists
American College of Osteopathic Surgeons
American Pediatric Surgical Association
American Society for Metabolic and Bariatric Surgery
American Society for Surgery of the Hand
American Society of Colon and Rectal Surgeons
American Society of Plastic Surgeons
American Urogynecologic Society

American Urological Association
Congress of Neurological Surgeons
Society for Vascular Surgeons
Society of American Gastrointestinal and Endoscopic Surgeons
Society of Gynecologic Oncology
The Society of Thoracic Surgeons