The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

July 14, 2020

Alex M. Azar II
Secretary, Department of Health and Human Services
Health Resources and Services Administration
200 Independence Avenue SW
Washington, DC 20201

Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244-8016

Re: Executive Order on Accelerating the Nation's Economic Recovery from the COVID-19 Emergency by Expediting Infrastructure Investments and Other Activities

Dear Secretary Azar and Administrator Verma:

On behalf of the American College of Obstetricians and Gynecologists (ACOG), the nation's leading women's health organization that represents over 60,000 physicians and partners dedicated to advancing women's health, thank you for your work to date to implement regulatory flexibilities in response to the COVID-19 pandemic. ACOG is appreciative of the actions taken by the agency to expand access to covered telehealth services and reduce administrative and regulatory burdens on physician practices so that patients can continue to receive needed obstetric and gynecologic care during the public health emergency. Obstetrician-gynecologists provide specialized care to women, including maternity care, gynecologic surgery, management of chronic conditions, and treatment for gynecologic cancer. Women's health practitioners also provide preventive services and serve as the entry point into the health care system for many women. These functions are essential to the nation's public health.

In Executive Order 13924, President Trump directed federal agencies to rescind, modify, waive, or provide exemptions from regulations or other requirements that may inhibit economic recovery, consistent with applicable law and with protection of the public's health and safety. **We are writing to urge HHS to implement appropriate regulatory measures to maintain certain policies implemented during the public health emergency and to encourage the adoption of other regulatory measures to promote patient access to care.** To assist the nation's economic recovery and to ensure access to safe, high quality gynecologic and obstetric health care, ACOG urges the Administration to continue and expand regulatory modifications made in response to the COVID-19 pandemic in order to:

- Improve access, coverage, and reimbursement for telehealth services.
- Secure the long-term stability of obstetrics and gynecology practices.
- Facilitate uninterrupted access to basic women's health care.
- Protect and expand access to care for low-income women and families.

Improve Access, Coverage, and Reimbursement for Telehealth Services

ACOG appreciates the agency's swift action to increase access to telehealth services during the COVID-19 pandemic. These policies expanded access to evidence-based care and demonstrated the viability of telehealth services as an effective means to provide essential obstetric and gynecologic care. Telehealth presents a significant opportunity to address the nation's maternal mortality crisis by increasing access to obstetric and gynecologic care for women. It is also uniquely positioned to assist the nation in its economic recovery by creating cost-effective and efficient ways for patients to access needed health services. ACOG urges the Department of Health and Human Services (HHS) to take the steps necessary to improve access to and reimbursement for telehealth services beyond the public health emergency.

Comparable health outcomes are achievable with telehealth when compared with traditional methods of health care delivery without compromising the patient–physician relationship.[1,2] Research has found that there are no significant differences in the rates of preterm birth, cesarean birth, neonatal intensive care unit admission, or low birth weight for women who received virtual prenatal visits in place of some in-person visits.[3,4] In fact, patient satisfaction was higher among women with virtual visits.[5] Remote patient monitoring and text message interventions have also been shown to improve the rate of adherence to blood pressure monitoring guidelines and reduce the number of unscheduled visits in the postpartum period.[6] Further, telehealth has been shown to address barriers to contraceptive access.[7]

In addition, telehealth could be used to improve women's access to behavioral health services and treatment for substance use disorder.[8,9] According to a 2019 study published in the *American Journal of Obstetrics and Gynecology*, substance use-related deaths were the second leading cause of death for women during the 12-month postpartum period, and suicide was the seventh leading cause of death during that same period.[10] Deaths caused by substance use disorder and suicide comprised a total of 18 percent of all maternal deaths captured in the case study.[11] In a recent study, researchers found that opioid use disorder treatment received via telehealth in obstetric practices was not associated with any statistically significant differences in outcomes compared to in-person treatment.[12] Behavioral health services and substance use disorder treatment provided via telehealth for pregnant and postpartum patients ensures access to the continuation of comprehensive care.

Permanently waive originating site and geographic requirements

ACOG strongly supports the Centers for Medicare & Medicaid Services' (CMS) decision to revise its originating site requirements to allow telehealth services to originate from the patient's home during the public health emergency. Longstanding policy narrowed the accessibility of telehealth to patients based on geographic standards and facility capabilities, whereas telehealth should be made available to all patients regardless of their geographic or physical location. We note that CMS has previously used rulemaking to expand access to some telecommunications-based services to patients in their homes. ACOG urges the agency to use its full authority to maintain these site expansions in recognition of the unique role that telehealth services will play in the nation's economic recovery.

Telehealth payment parity and site of service differential

ACOG strongly supports CMS's actions to affirm payment parity for telehealth services during the public health emergency (PHE). We also support the agency's decision to pay physicians practicing in office settings who see patients via telehealth at the non-facility rate for these services. Prior to the PHE, CMS paid office-based physicians the lower facility rate for Medicare telehealth services. This effectively creates a penalty for office-based physicians who deliver telehealth services and further disincentivizes the use of telehealth.

ACOG urges HHS to maintain payment parity and ensure that evaluation and management (E/M) services provided via audio-only or telehealth services are paid at the same rate as in-person E/M visits after the end of the PHE. These actions are essential to ensure ongoing provision of evidence-based care, support the long-term financial well-being of physician practices, and in turn bolster the economy. Obstetrician-gynecologists report that implementing telehealth in their practices requires a significant financial investment due to the infrastructure and staff time required, amid a period when practices face significant financial strain. Absent true payment parity, physician practices may be forced to reduce the number of telehealth services they offer. ACOG strongly recommends that HHS make telehealth payment parity permanent.

ACOG also strongly supports the agency's efforts to permit the use of audio-only equipment for certain evaluation and management services, behavioral health counseling, and educational services. Reimbursement for these services will allow patients without access to video-based technologies, including access to broadband internet, to receive needed care. To facilitate access to care, ACOG urges CMS to maintain coverage and payment parity for the telephone E/M services [Current Procedural Terminology (CPT) codes 99441-99443]. Coverage of audio-only services is essential to ensuring equitable access to telehealth services among Medicare beneficiaries.

Telehealth service expansion
In response to the public health emergency, the agency expanded coverage and payment for Medicare telehealth services by adding services to the list of eligible telehealth services, eliminating frequency limitations and other requirements, and clarifying payment rules that apply to other services furnished through telecommunication technologies that can reduce exposure risk to COVID-19. ACOG recommends that CMS maintain the expanded list of covered telehealth services, including allowing E/M and technology-based communications services to be delivered to new patients via telehealth. We also urge CMS to maintain the sub-regulatory process that was established during the public health emergency for adding services to the telehealth services list after the conclusion of the public health emergency consistent with its existing regulatory authority. ACOG recommends that CMS use this process to add the codes listed in **Appendix 1** to the Medicare telehealth services list.

Expand access to patient monitoring and durable medical equipment
ACOG applauds CMS's decision to allow remote patient monitoring to be used for both new and established patients, as well as acute and chronic conditions. ACOG recommends that expanded access to remote patient monitoring services is maintained after the PHE, particularly for pregnant and postpartum women who are covered by Medicare.

An internal analysis revealed that Medicare covered more than 11,000 births in 2018.[13] Due to Medicare eligibility requirements, pregnant and postpartum women who are covered by Medicare are more likely to have comorbid conditions and complications during pregnancy, making access to remote patient monitoring services essential. Remote patient monitoring and text message interventions have been shown to improve the rate of adherence to blood pressure monitoring guidelines and reduce the number of unscheduled visits in the postpartum period.[14] ACOG guidance indicates that blood pressure and weight monitoring are essential to comprehensive prenatal care and, therefore, coverage of this equipment is medically necessary.[15,16] Further, absent the COVID-19 pandemic, many pregnant and postpartum women prefer telehealth visits over some in-person appointments.[17] Therefore, ACOG strongly urges CMS to expand the Medicare Part B Durable Medical Equipment (DME) benefit to include at-home blood pressure, pulse oximetry, and weight monitoring equipment for all pregnant and

postpartum beneficiaries so that patients can access the at-home equipment they need for remote prenatal and postpartum visits via a prescription.

Support and encourage expanded access to telehealth coverage for Medicaid enrollees
ACOG commends the steps that HHS has taken in recent months to facilitate expanded telehealth coverage and access in the Medicaid program during COVID-19. We strongly recommend that HHS use its existing authority to encourage states to improve coverage of telehealth services for women covered by Medicaid beyond the COVID-19 pandemic. Medicaid is a primary source of health coverage for women across the lifespan. Indeed, 25 million adult women were covered by Medicaid in 2014 and 43 percent of births were financed by Medicaid in 2018.[18,19] It is vital that these women have access to evidence-based telehealth services, both as the COVID-19 pandemic continues and in perpetuity.

ACOG Recommendations:

- Use existing authorities to remove originating site restrictions to allow telehealth services to be provided to all Medicare beneficiaries in their home, regardless of geographic location.
- Permanently establish payment parity for telehealth and audio-only E/M services and ensure telephone E/M services (CPT codes 99441-99443) are covered for all patients.
- Pay office-based physicians the non-facility rate for telehealth services after the PHE ends.
- Permanently allow services on the Medicare telehealth list to be provided to new patients.
- Make permanent the sub-regulatory process recently established to add services to the Medicare telehealth services list.
- Maintain or add each of the CPT codes included in **Appendix 1** to the Medicare telehealth services list.
- Maintain expanded coverage of remote patient monitoring services and include pregnant and postpartum beneficiaries.
- Cover remote patient monitoring services for all pregnant and postpartum beneficiaries.
- Expand the Part B DME benefit to make the necessary durable medical equipment, including at-home monitoring equipment such as blood pressure, pulse oximetry, blood glucose, and weight monitors, available via prescription for all pregnant and postpartum beneficiaries.
- Use existing authority to encourage states to improve coverage of telehealth services for women covered by Medicaid.

Secure the Long-term Stability of Obstetrics and Gynecology Practices
ACOG appreciates the actions HHS has taken to support physician practices amid the COVID-19 pandemic, including funds disbursed through the Provider Relief Fund and the Medicare Advanced and Accelerated Payment Programs. Unfortunately, obstetrician-gynecologists continue to report that their practices face ongoing dramatic financial challenges and fear they will have to close permanently. Many have been forced to furlough staff members, temporarily close their doors, and forgo pay in order to keep their practices afloat during the pandemic.

Provide equitable financial relief to all obstetrics and gynecology practices
We commend HHS for recently opening the Enhanced Application Portal so that clinicians who care for patients covered by Medicaid and the Children's Health Insurance Program (CHIP) and were excluded from previously allocated funds can apply for relief funds. However, obstetrician-gynecologists on the front lines of responding to the pandemic report that their practices have suffered devasting financial losses, with some patient volumes decreasing by 75 percent.[20] After months of cancelling non-urgent services, most women's health practices will be unable to make up the revenue they have lost due to

COVID-19. Liability insurance costs, rent, and utility payments are added to increased operating costs due to purchasing personal protective equipment for their patients and staff. At the same time, physicians are reducing the number of available appointments to ensure social distancing guidelines can be maintained, and many patients are concerned about seeking in-person care as the pandemic continues. Obstetrician-gynecologists will be forced to evaluate the long-term financial viability of their practices, and without additional financial relief, many may have to close their doors or sell their practice to a large health system.

Several obstetrician-gynecologists that received a small direct deposit of funds through the first $50 billion allocated were not aware of the requirement to apply through the General Distribution Portal before June 3, 2020 in order to receive additional funds. These reports were confirmed by an internal analysis of the public Provider Relief Data file, which found that as of June 19, 2020, the median amount of funds provided to women's health practices was $3,241, which is not equal to two percent of total annual revenue for any practice. ACOG believes that HHS should reopen the General Distribution Portal for clinicians that did not submit for the second allocation of additional funds.

Practices that did not bill Medicare fee-for-service during the fourth quarter of 2019 and do not care for patients covered by Medicaid were not eligible for either the first $50 billion in funds allocated, nor the new Medicaid and CHIP allocation. Many obstetrician-gynecologists primarily care for women of reproductive age who are not yet eligible for Medicare and therefore they do not regularly bill Medicare fee-for-service. Private insurance, however, serves as a primary source of health care coverage for women across the lifespan. In 2018, 60 percent of women between the ages of 19-64 were covered by employer-based insurance and 49 percent of births were covered by private insurers.[21,22] Many older women receive their coverage through Medicare Advantage plans, with women making up 57 percent of Medicare Advantage enrollees in 2016.[23] The obstetrician-gynecologists who care for women insured through these plans should not be excluded from receiving federal relief funds.

This inequitable method of distributing funds is not reflective of congressional intent. Congress allocated these federal relief funds for all physician practices facing financial strain due to COVID-19, regardless of their patient mix. ACOG strongly urges HHS to immediately take steps to ensure that all obstetrics and gynecology practices receive relief funds of at least two percent of their total annual revenue. Specifically, we recommend that HHS open an application portal for all physician practices that have been excluded from receiving funds through either the $50 billion or the $15 billion allocation for clinicians participating in Medicaid and CHIP. It is vital that all obstetrics and gynecology practices receive equitable financial relief during this challenging time.

Delay implementation of final rules on Advancing Interoperability and Patient Access to Health Data and Interoperability, Information Blocking, and Health IT Certification Program

CMS and the Office of the National Coordinator for Health Information Technology (ONC) finalized the interoperability and patient access rules with an effective date of six months following publication in early March 2020, the start of the public health emergency. ACOG appreciates that HHS delayed the implementation date for these rules an additional six months in recognition of the resources required to respond to COVID-19. Obstetrician-gynecologists and other women's health practitioners should be relieved from unnecessary administrative requirements as the COVID-19 pandemic continues to impact their practices and their patients. Specifically, we recommend that CMS delay publicly reporting clinicians' responses to the Promoting Interoperability (PI) information blocking attestation on Physician Compare until at least the 2021 performance year. The policy requiring the public reporting of clinicians

that were not able to update digital contact information in the CMS National Plan and Provider Enumeration system should also be delayed by at least full year. Finally, ONC should delay information block enforcement for at least an additional six months, which would make the information blocking policy applicable, at the earliest, within 12 months after the final rule is published in the Federal Register.

Modify the Quality Payment Program to ensure clinicians are not unfairly penalized
ACOG appreciates the recent announcements from CMS detailing flexibilities for the Merit-based Incentive Payment System (MIPS) and for various Alternative Payment Models (APMs). However, we remain concerned that obstetrician-gynecologists and other clinicians participating in the Quality Payment Program (QPP) could face additional financial strain if further action is not taken. ACOG recommends that CMS automatically hold clinicians harmless from MIPS penalties for performance year 2020 and exempt any 2020 performance data from public reporting on Physician Compare. ACOG further recommends that CMS hold APM participants harmless from both downside risk and performance-based adjustments that will negatively impact model payments for performance year 2020. We believe these protections are essential to ensuring that physicians are not unfairly penalized due to circumstances outside of their control.

ACOG Recommendations:

- Re-open the General Distribution Portal for practices that were unable to meet the June 3rd deadline to apply for supplemental funds and ensure they receive relief equal to 2 percent of their total annual revenue.
- Open an application portal for all physician practices that have been excluded from receiving funds through either the $50 billion or the $15 billion allocation for clinicians participating in Medicaid and CHIP and ensure they receive relief of at least 2 percent of their total annual revenue.
- Delay publicly reporting clinicians' responses to the PI information blocking attestation on Physician Compare. The 2019 and 2020 performance years should not be reported.
- A minimum one-year delay in the policy that requires the public reporting of which clinicians were not able to update digital contact information in the CMS National Plan and Provider Enumeration System.
- Delay information blocking enforcement for at least an additional six months, which would make the information blocking policy applicable, at the earliest, within 12 months after the rule has been published in the Federal Register.
- Hold clinicians harmless from MIPS penalties for performance year 2020.
- Refrain from publicly reporting any data from the 2020 performance year on Physician Compare.
- Hold APM participants harmless from downside risk payments and negative adjustments for the 2020 performance year.

Facilitate Uninterrupted Access to Basic Women's Health Care
While it is unclear how long the COVID-19 pandemic will last and what the full extent of its impact on the health care system will be, it is imperative that access to medical care be prioritized. This includes access to basic women's health services as well as access to any willing provider.

Rescind CMS-9922-F: Exchange Program Integrity
Finalized in December of 2019, the Exchange Program Integrity rule requires qualified health plan (QHP) issuers to send (and QHP enrollees to pay) two separate monthly premium payments for the portion of coverage that is attributable to abortion services and the portion attributable to all other health care services.[24,25] As outlined in ACOG's April 16, 2020 letter to HHS and CMS, continued implementation of this regulation will have significant economic consequences for health plans, increase costs to states, result in more uninsured individuals, and compromise the ability of Americans to obtain access to care during the COVID-19 pandemic.[26] While we are pleased that the Administration delayed implementation of the rule by 60 days, we urge CMS to permanently rescind the separate billing requirement.

As proposed, the separate billing requirement would place immense administrative burdens on clinicians, patients, and health plans at a precarious time. According to HHS, implementation of the rule will cost health plans an additional $4.1 million in contracting costs for system changes and overtime personnel payments.[27] HHS also predicted that the one-time costs to bring all affected issuers across the country (94 in total across 21 states offering a total of 1,467 plans) into compliance and implement the necessary technical changes would require over 2.9 million hours of work and cost approximately $385 million.[28] HHS also estimates that, on average, each state Exchange will incur one-time costs of $750,000.[29] For state-based Exchanges that permit the sale of QHPs offering the full scope of reproductive health care, those one-time costs will total approximately $9 million, with ongoing costs of $2.4 million for 2020 alone.[30] It is likely that these HHS estimates are now not fully reflective of the actual costs of implementation as more individuals look to the Exchanges for coverage due to job loss as a result of COVID-19.[31]

This rule will only serve to limit access to comprehensive women's health coverage in QHPs, thereby threatening women's health and their ability to fully participate in and contribute to the nation's economic recovery. We strongly urge HHS to permanently rescind this regulatory requirement.

Guarantee access to any willing provider
On January 19, 2018, the Administration released guidance to state Medicaid agencies titled "Rescinding SMD #16-005 Clarifying "Free Choice of Provider" Requirement."[32] This guidance rescinded an April 2016 document requiring state Medicaid programs to comply with Section 1902(a)(23) of the Social Security Act pertaining to freedom of choice and any willing provider.[33] In effect, the 2018 guidance grants states the opportunity to exercise their authority to violate critical patient protections by barring certain women's health care clinicians from their state Medicaid programs.

ACOG strongly opposes changes to Medicaid that discriminate against otherwise qualified health care professionals by denying them state or federal funding.[34] Medicaid's freedom of choice and any willing provider protections ensure that Medicaid patients may choose the clinician and the treatments that best suit their needs, without outside interference. These patient protections are even more critical in the midst of a public health crisis, when access to care is severely limited. ACOG urges the agency to withdraw the January 2018 rescission along with policies and programs that were approved as a result of wrongful guidance.[35]

Issue guidance to the states regarding ongoing use of HHS Form 687: Consent for Sterilization
The current processes and required documentation for publicly funded sterilization procedures interfere with patients' ability to access care, particularly impacting those who receive health coverage through Medicaid. These inequities have been exacerbated by the COVID-19 pandemic. HHS Form 687: *Consent*

for Sterilization, is required by federal law for federally financed beneficiaries to receive a sterilization procedure. Once signed, the signature is valid for 180 days, and the patient must wait a minimum of 30 days before receiving their desired sterilization. In many states these procedures, particularly those that occur on an interval basis (not immediately following a vaginal or cesarean delivery), have been rescheduled or delayed in the wake of COVID-19. These delays and the stringent interpretation of federal guidance by state Medicaid agencies have created bureaucratic barriers to desired sterilization for many women during the pandemic. ACOG requests that HHS issue clarifying guidance on the use of electronic signatures, telehealth, and time limitations for publicly funded sterilization procedures.

ACOG Recommendations:

- Rescind CMS-9922-F: Exchange Program Integrity.
- Withdraw the 2018 "Rescinding SMD #16-005 Clarifying "Free Choice of Provider" Requirement" guidance document pertaining to the "freedom of choice" and "any willing provider" sections of the Social Security Act and approval of related policies or demonstration programs.
- Issue clarifying guidance to the states on the use of electronic signatures, telehealth, and time limitations for publicly funded sterilization procedures.

Protect and Expand Access to Care for Women and Families with Low-Incomes

The COVID-19 pandemic starkly demonstrates that regulatory actions are needed to protect and expand access to care for women and families with low incomes, including those eligible for Medicaid and the uninsured. Women, on average, earn lower wages, have fewer financial assets, accumulate less wealth, and have higher rates of poverty than men.[36,37] Women are also more likely than men to report forgoing needed health care due to cost (26 percent of women vs. 19 percent of men).[38] ACOG urges HHS to adopt policies that ensure that individuals with low incomes have access to needed care.

Extend Medicaid coverage for pregnant women beyond 60 days postpartum

Amid the COVID-19 public health emergency, the United States continues to experience a maternal mortality crisis. The United States is the only well-resourced nation with a maternal mortality rate that is on the rise, increasing 26 percent between 2000 and 2014.[39] Also concerning are the stark racial inequities in maternal mortality: Black women are three to four times more likely to die from a pregnancy-related complication than non-Hispanic white women.[40] Adverse maternal health outcomes are also more common among women who rely on Medicaid for pregnancy-related care. This is due, in part, to the fact that under current law women who are eligible for Medicaid on the basis of being pregnant become ineligible for coverage roughly 60 days after the end of pregnancy.[41]

Prior to the COVID-19 pandemic, several states began working to extend Medicaid coverage for postpartum women beyond the arbitrary 60-day cliff. Most are pursuing this policy solution under Section 1115 waiver authority, and three states currently have applications pending with CMS. As each state application makes clear, Medicaid has a critical role to play in protecting our nation's mothers from adverse maternal health outcomes, including those linked to COVID-19. Given these two public health crises and their unique impact on pregnant and postpartum women, particularly women of color, ACOG urges HHS – acting through CMS – to swiftly review and approve Section 1115 waiver applications that seek to extend Medicaid coverage for pregnant women beyond 60 days postpartum.

Encourage the remaining states to expand Medicaid under the Affordable Care Act

The importance of the Medicaid program during a public health emergency cannot be overstated. With the COVID-19 pandemic, this importance is magnified due to the incredible loss of jobs and resultant

economic downturn. In states that have expanded Medicaid under the Affordable Care Act (ACA) to low-income, childless adults, most people who have lost their jobs or seen sharp drops in income have been able to get covered. Conversely, in non-expansion states many individuals have become uninsured. Indeed, if the remaining 13 states expanded eligibility, over four million Americans would be eligible for coverage.[42] Notably, more than half of these individuals are women.

The benefits of expanding Medicaid extend beyond the COVID-19 pandemic. Research shows that Medicaid expansion increases access to care, improves financial security, and saves lives.[43] Medicaid expansion was significantly associated with 7.01 fewer maternal deaths per 100,000 live births relative to non-expansion states.[44] Among non-Hispanic Black mothers, Medicaid expansion was found to be significantly associated with 16.27 fewer maternal deaths per 100,000 live births relative to non-Hispanic Black mothers in non-expansion states. ACOG urges CMS to encourage the remaining 13 states to implement Medicaid expansion, and to reject coverage conditions such as premiums, lockout periods, or work and community engagement requirements.

Invite states to extend waivers to provide coverage for testing and treatment of the uninsured
As part of the CMS response to COVID-19, the agency quickly reviewed and approved dozens of regulatory requests from the states, including Medicaid Disaster Relief State Plan Amendments (SPAs), other Medicaid and CHIP SPAs, Section 1115 waivers, Section 1135 waivers, and 1915 (c) waiver Appendix K strategies.[45] The Families First Coronavirus Response Act created a state plan option to provide coverage to the uninsured for COVID-19 testing and related visits under the Medicaid state plan. To date, 16 states (AL, AZ, CA, CO, IA, IL, LA, ME, MN, MT, NH, NM, RI, SC, UT, WA) are providing this coverage under a temporary disaster relief SPA.[46]

Although much remains uncertain about the SARS-CoV-2 virus and the COVID-19 pandemic, epidemiological experts increasingly expect that the virus will be endemic – that is, regularly occurring within the population – for the foreseeable future.[47] As a result, people will continue to need access to timely testing and treatment for COVID-19, regardless of insurance status. ACOG urges CMS to work with the states to continue their regulatory initiatives to provide testing to the uninsured beyond the length of the national emergency.

Abandon the theory that work requirements make people healthier
In January 2018, CMS released guidance to state Medicaid agencies titled “Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries.”[48] This guidance document outlined the Administration’s priorities for the Medicaid program, namely its willingness to “support state efforts to test incentives that make participation in work or other community engagement a requirement for continued Medicaid eligibility or coverage for certain adult Medicaid beneficiaries in demonstration projects authorized under section 1115 of the Social Security Act.”[49] Since the release of this guidance, CMS has approved 10 state requests to implement work and community engagement requirements (AZ, AR, IN, KY, MI, NH, OH, SC, UT, WI).[50] Importantly, none of these states are currently implementing and four of these approvals have been vacated by federal courts.

Work and community engagement requirements are antithetical to the long-standing objectives of the Medicaid program and stand only to create unnecessary barriers to coverage. In Arkansas, for example, more than 18,000 people (nearly one in four of those subject to similar work and community engagement requirements) lost coverage over the course of just seven months. In New Hampshire, almost 17,000 people, or about 40 percent of those who would have been subject to work

requirements, would have lost coverage had state policymakers not put the policy on hold. In Michigan, almost 80,000 people were at risk of losing coverage before a court put its policy on hold. The experiences of these states demonstrate that without access to necessary care, people's health will suffer and so will their ability to work.

Additionally, the current economic climate is not conducive to an eligibility criteria based on an individual's job status when there are simply less jobs to be had.[51] To best ensure individuals can maintain their health, HHS should not hold states accountable to waiver approvals granting states the authority to implement work and community engagement requirements.

Do not finalize CMS-2393-P: Medicaid Program; Medicaid Fiscal Accountability Regulation
In January 2020, ACOG submitted public comments in opposition to the Medicaid Fiscal Accountability Regulation (MFAR). If finalized as proposed, MFAR would alter the options for states to finance their share of the Medicaid program and enforce new requirements on supplemental payments to physicians. This would result in states being forced to reduce eligibility, cut benefits and services, increase beneficiary cost-sharing, or limit clinician payments. The impact of this regulation is incredibly concerning, especially in the face of the COVID-19 pandemic and our nation's rising rates of maternal mortality and severe maternal morbidity. To best ensure that state Medicaid programs are able to fully finance their share of the program in the aftermath of COVID-19, this rule should not be finalized.

Create a special enrollment period to allow individuals to make changes to their health insurance and add 'pregnancy' to the list of qualifying life events
The COVID-19 pandemic is making many people realize that their health care coverage may be insufficient to meet their needs. This time of pandemic should prompt the temporary opening of the Affordable Care Act's health insurance marketplace (Exchange) to enable people to newly enroll in coverage. Any COVID-19 special enrollment period (SEP) should also allow individuals with high-deductible health plans or short-term, limited-duration insurance to select a new health plan that better meets their needs and that can best help them avert the potential of medical debt.

In addition, ACOG has long advocated for pregnancy to be considered a qualifying life event that triggers eligibility for an SEP. Due to restrictions under current regulation, if an uninsured woman becomes pregnant outside of the annual open enrollment period – and is not otherwise eligible for other insurance such as Medicaid or CHIP – she may be unable to access health insurance for the duration of her pregnancy. This may lead some women to forgo pregnancy-related care altogether because, absent insurance, they would need to pay for the full cost of care on their own. The average cost for an uncomplicated vaginal delivery in 2012 was $23,000.[52] This amount would be financially untenable for many women and families without the aid of insurance. Establishing an SEP based on pregnancy would eliminate this gap and get more women into timely prenatal care.

There is a large body of research which demonstrates that improved access to prenatal care improves maternal and infant health outcomes.[53,54,55,56,57,58,59] Additional studies confirm that women with unstable health insurance coverage during pregnancy are more likely than women with stable coverage to report entering prenatal care after the first trimester.[60] For more than thirty years, the United States – through the Medicaid program – has recognized pregnancy as a point at which women need immediate access to care through coverage expansions and presumptive eligibility based on pregnancy status.[61] Women eligible for coverage on the Exchange have not been given the same priority status.

During the COVID-19 pandemic – when the country's staggering rate of maternal mortality has great potential to worsen – it is important for HHS and CMS to prioritize the unique needs of pregnant women. Creating an SEP for pregnancy is especially important for women who may lack access to coverage that includes maternity benefits. Enacting this policy would ultimately save the health care system money by increasing the likelihood of a positive birth outcome for the woman and a safe and successful delivery of a healthy newborn.

ACOG Recommendations:

- Review and approve Section 1115 waiver applications that seek to extend Medicaid coverage for pregnant women beyond 60 days postpartum.
- Work with the remaining 13 states to implement Medicaid expansion as quickly as possible.
- Work with the states to implement the proper waiver flexibilities to continue their initiatives to provide COVID-19 testing to the uninsured.
- Abandon the theory that work makes people healthy and rescind current waiver approvals granting states the authority to implement work and community engagement requirements.
- Do not finalize CMS-2393-P: Medicaid Program; Medicaid Fiscal Accountability Regulation.
- Create a special enrollment period to allow individuals to make changes to their health insurance and add 'pregnancy' to the list of qualifying life events.

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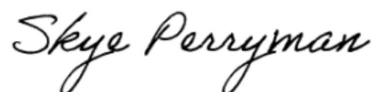
Thank you for your consideration of our comments as you continue to respond to the COVID-19 public health emergency and advance our nation's economic recovery. ACOG looks forward to our ongoing partnership to ensure beneficiaries' access to affordable, high-quality women's health care. Should you have any questions or wish to discuss these recommendations further, please contact Lisa Satterfield, Senior Director of Health Economics and Practice Management, at lsatterfield@acog.org.

Sincerely,



Skye L. Perryman, JD
Chief Legal Officer

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Appendix 1: ACOG Recommended Covered Telehealth Services

ACOG Recommendations: Services to Keep on the Medicare Telehealth Services List	
Code	**Code Description**
96160	Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument
96161	Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or

	minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
99217	Observation care discharge day management
99218	Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.
99219	Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.
99220	Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.
99221	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital

	floor or unit.
99222	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.
99223	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.
99224	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: Problem focused interval history; Problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.
99225	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.
99226	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.
99231	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.
99232	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.
99233	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least

	2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.
99234	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of low severity. Typically, 40 minutes are spent at the bedside and on the patient's hospital floor or unit.
99235	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.
99236	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of high severity. Typically, 55 minutes are spent at the bedside and on the patient's hospital floor or unit.
99238	Hospital discharge day management; 30 minutes or less
99239	Hospital discharge day management; more than 30 minutes
99281	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.
99282	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.
99283	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.

99284	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.
99285	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
99354	Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour
99355	Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes
99356	Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient Evaluation and Management service)
99357	Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes
99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided 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
99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided 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
99443	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided 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
99473	Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration
G0406	Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth
G0407	Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with

	the patient via telehealth
G0408	Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth
G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth
G0426	Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth
G0427	Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth
G0436	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes
G0437	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes
G0438	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit
G0439	Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit
G0442	Annual alcohol misuse screening, 15 minutes
G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
G0444	Annual depression screening, 15 minutes
G0445	Semiannual high intensity behavioral counseling to prevent STIs, individual, face-to-face, includes education skills training & guidance on how to change sexual behavior
G0447	Face-to-face behavioral counseling for obesity, 15 minutes
G0459	Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
G0513	Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (list separately in addition to code for preventive service)
G0514	Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (list separately in addition to code G0513 for additional 30 minutes of preventive service)

ACOG Telehealth Code Recommendations: Add to the Medicare Telehealth Services List	
Code	**Code Description**
G0508	Telehealth consultation, critical care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth
G0509	Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth

Durable Medical Equipment (DME) HCPCS Codes to Cover for Pregnant and Postpartum Women
Blood Pressure Monitoring

A4660	Sphygmomanometer/blood pressure apparatus with cuff and stethoscope
A4663	Blood pressure cuff only
A467	Automatic blood pressure monitor
Blood Glucose Monitoring	
E0607	Home blood glucose monitor
E2100	Blood glucose monitor with integrated voice synthesizer
E2101	Blood glucose monitor with integrated lancing/blood sample
Pulse Oximetry	
94760	Noninvasive ear or pulse oximetry for oxygen saturation; single determination
Weight Scale	
E1639	Scale, each