

May 7, 2020

Seema Verma  
Administrator  
Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
200 Independence Avenue SW  
Washington, DC 20201

Dear Administrator Verma:

On behalf of the American College of Physicians (ACP), I write to express our appreciation of the [announcement](#) from the Centers for Medicare and Medicaid Services (CMS) that the agency will begin paying for telephone calls between patients and their physicians at a rate equal to in-office visits, as requested by ACP in many previous communications to CMS. We are heartened by CMS' responsiveness to our input and the concerns of our physician-members. Most importantly, CMS' decision will have a very positive impact and will help struggling physician practices remain open while facilitating telephone consultations with their patients. Additionally, we appreciate the many other regulatory actions taken to date by the agency to address the unprecedented public health emergency (PHE) caused by the COVID-19 pandemic. These actions have been extremely helpful to physicians and their patients in these unprecedented times.

The American College of Physicians is the largest medical specialty organization and the second largest physician membership society in the United States. ACP members include 159,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness. Internal medicine specialists treat many of the patients at greatest risk from COVID-19, including the elderly and patients with pre-existing conditions like diabetes, heart disease, and asthma.

In recognition of and appreciation for the significant actions taken by the agency during this pandemic, ACP wishes to continue the constructive dialogue we have had with CMS. We believe that the actions taken by CMS in conjunction with our requests below will provide further stability to practices and enhance patient care and delivery. At this time, the College requests that CMS consider the following steps to build on existing actions that have already cut red tape and enhanced care delivery:

- Accelerated and Advance Payment Program:
  - Allow the payment program to resume to help struggling physician practices stay open;
  - Retroactively extend the payment program recoupment period to begin one year after payment receipt. Additionally, allow physicians one year to repay the loan interest-free;
  - Reduce the per-claim recoupment amount from 100% to 25% to allow practices to continue billing Medicare while paying back the advance over an extended period of time; and

- Permit practices to apply for a second advanced payment using similar rules, should the pandemic continue indefinitely.
- Provider Relief Fund:
  - Establish an appeals process to provide physicians with an avenue to adjudicate payment disputes; and
  - Make the application process less burdensome by offering additional flexibility to prove financial need.
- Medicare Fee-For-Service Changes:
  - Adopt the same documentation guidelines for telephone E/M claims as those for telehealth E/M claims;
  - Provide flexibility in documenting annual wellness visits (AWVs) when conducted via telehealth;
  - Temporarily waive all prior authorization requirements during this period of national emergency;
  - Further delay reporting of 2019 Merit-Based Incentive Payment System (MIPS) data to the end of 2020 and immediately implement automatic extreme and uncontrollable circumstances hardship exceptions for both the 2019 and 2020 performance years; and
  - Hold Advanced APM participants harmless from risk-based payments for the 2020 performance year and extend key participation deadlines, delay scheduled advances to higher risk tracks, and offer contract extensions.

We discuss these requests in more detail below.

### **Accelerated and Advance Payment Program**

The agency's provision of economic relief to physicians during this PHE has been an important lifeline for practices experiencing significant economic losses due to pandemic relief efforts. Some practices have benefited from the Provider Relief Fund and other programs authorized by Congress and administered by CMS; however, these programs have not been sufficient to make practices whole for lost revenue and increased costs associated with the COVID-19 emergency. For many, the Accelerated and Advance Payment Program remains a critically important option that can help them keep their doors open. **Therefore, we are greatly concerned by CMS' decision to suspend the Accelerated and Advance Payment Program, and urge that it be resumed immediately to help struggling physician practices to stay open.**

We also believe that as the program is re-opened, changes should be made to make it more effective. The impact of the pandemic is expected to last a considerable amount of time, leading to ongoing, significant cash-flow problems for primary care practices and uncertain timing regarding when they may be able to return to full operations. Under the current rules, advance payment recipients have from 120 days (roughly four months from receipt of the payment) to 210 days (roughly three months hence) to repay the loan interest-free. Afterward, recipients must make payments at a rate of 10.25%, a rate much higher than other typical loans. The issue is that claim payments coming in during that same period (from four to seven months after the initial advance payment was received) will have to be immediately paid out in loan payments. This effectively cancels out Medicare revenues during the same time period, thus requiring practices to lose revenues again in another four months.

Recouping the entirety of the advance payment by offsetting 100% of Medicare claims until the balance is repaid merely postpones the cash-flow problems practices are currently experiencing until a later date, when it is unlikely that patient volume will be back to pre-COVID-19 levels. **Therefore, the College recommends that CMS retroactively extend the recoupment period to begin 365 days after receipt of the payment, after which the recipient will have one year to repay the advance interest-free.** This change will allow repayments to be spread out over a longer period of time. **ACP also recommends that CMS reduce the per-claim recoupment amount from 100% to 25% to allow practices to continue billing Medicare while paying back the advance over an extended period of time.**

We believe that these changes will allow physician practices to extend repayment of these zero-interest loans over the course of 2021 and focus immediately on the needs of their patients and communities, such as implementing telehealth, and keeping the lights on until other procedures and visits can ramp back up. Many physicians have already had to make difficult decisions about reducing operations, taking pay cuts, and furloughing staff, even while they are preparing for and treating a surge of COVID-19 cases.

### **Provider Relief Fund Payments**

There is no doubt that the Provider Relief Fund payments have been extremely helpful to those physicians that have received them. While most eligible physicians did receive their payment in the first distribution, we are aware that some did not. ACP has been unable to find out from information posted by CMS the reasons why some physicians did not receive a payment. In addition, we are not aware of an appeals process, or an ability for those practices that were left out originally to apply for the second distribution, since the second distribution is only available to those who received the first distribution. The process for the second round of distribution also requires an application. While the application is fairly simple, for many small practices it requires the help of a financial advisor, such as a Certified Public Accountant (CPA), to complete the application.

**Given these concerns, ACP recommends that CMS establish an appeals process to provide physicians with an avenue to adjudicate payment issues.** The College strongly supports transparency about eligibility determination and payment calculation. **ACP also recommends making the application process less burdensome by offering additional flexibility to prove financial need. For example, CMS could allow patient volume and charges to serve as other indicators of reduced productivity. These measures can be provided by the practice's electronic health record (EHR), billing system, or by attestation.** These means are much more attainable than requiring the assistance of a professional financial advisor at a time when some practices are struggling just to make payroll.

### **Pay Parity for Telephone E/M Claims and Documentation Guidelines**

As noted earlier, the College wholeheartedly supports the agency's actions to provide additional flexibilities for patients and their doctors by providing payment for telephone E/M services — and more recently, the decision to provide payment parity between *telehealth* E/M codes 99201-99215 and *telephone* E/M codes 99441-99443 by cross-walking telephone E/M codes to E/M codes 99212-99214 and adding these codes to the Medicare telehealth list. These changes in payment policy address some of the biggest issues facing physicians as they struggle to make up for lost revenue and provide appropriate care to patients. The College values the opportunity to communicate with CMS about these issues, and we are very appreciative of the agency's receptiveness to our concerns by adopting these recommended changes.

To build on these positive changes, ACP recommends that CMS establish clear guidelines around billing for telephone E/M claims. The agency did note that the office/outpatient E/M level of selection for telehealth E/M services can be based on medical decision-making (MDM) or time, with time defined as all of the time associated with the E/M visit on the day of the encounter. In regards to telehealth, CMS also finalized a policy to temporarily remove any requirements regarding documentation of history and/or physical exam in the medical record, while maintaining the current definition of MDM. **Given the realities of the current PHE and the need to ensure patient access to care, we strongly recommend that CMS adopt these same documentation guidelines for telephone E/M claims as they did for telehealth services in order to provide clarity and consistency for physicians.**

Medicare Annual Wellness Visits (AWV, G0438 and G0439) are vital to determining the general status of a patient's health and give patients the opportunity to talk to their physician about any health concerns or ongoing pain or symptoms they may be experiencing. ACP requests that CMS provide clarity as soon as possible to physicians to aid in understanding how AWVs can be delivered in patients' homes when some elements of visits necessitate an in-person visit: measuring of height, weight, and blood pressure for example. **The College asks that CMS provide flexibility in documenting Annual Wellness Visits when conducted via telehealth, including allowing patient-reported vital signs like height, weight, and blood pressure (for patients who have the ability, there are apps available that very accurately capture patients' temperature and blood pressure). These flexibilities are important and requires Medicare Administrative Contractors to provide consistent guidance.**

#### **Prior Authorization**

In previous letters, the College has detailed the extensive problems with prior authorization during a PHE. As we have noted, utilization management hurdles have become even more apparent and problematic given the current COVID-19 national emergency, precisely when frontline physicians need to focus their time and resources on curtailing the pandemic. The numerous and varying requirements for prior authorization requests deflect practices' resources away from direct patient care and can result in care delays that negatively impact patient outcomes and well-being. ACP members have raised specific concerns regarding hospital patients that are awaiting prior authorization approval for discharges into Skilled Nursing Facilities. These delays are ranging from four days to two weeks, thus resulting in patients occupying hospital beds that could be used during this national health emergency. Additionally, there are cost effects of prior authorization burden on physician practices as well, with the annual average cost of these activities on primary care physicians ranging from \$2,161 to \$3,430 per full-time employee.<sup>1</sup> While we appreciate the numerous ongoing efforts to streamline and automate the prior authorization process more broadly, and we understand the stress on federal and state budgets without utilization controls, more action needs to be taken during this national health emergency. Those working on the front lines to address the COVID-19 pandemic need immediate relief from unnecessary administrative tasks that add cost to their practice and ultimately delay care. **Therefore, ACP reiterates our recommendation that CMS work through all appropriate channels to temporarily waive all prior authorization requirements during this period of national emergency.**

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<sup>1</sup> Erickson SM, Rockwern B, Koltov M, et al, for the Medical Practice and Quality Committee of the American College of Physicians. Putting Patients First by Reducing Administrative Tasks in Health Care: A Position Paper of the American College of Physicians. Ann Intern Med. 2017;166:659–661. [Epub ahead of print 28 March 2017]. doi: <https://doi.org/10.7326/M16-2697>

## Quality Payment Program

ACP appreciates the steps the Administration has taken to date to alleviate administrative burdens on clinicians during this difficult time but urges that additional steps be taken to provide immediate relief to frontline clinicians by implementing the following recommended changes in the Quality Payment Program (QPP).

- 1. For the Merit-based Incentive Payment System (MIPS), the College recommends CMS immediately implement automatic extreme and uncontrollable circumstances hardship exceptions for both the 2019 and 2020 performance years.**

ACP appreciates that CMS will grant a MIPS automatic exception to those that do not submit 2019 data and will offer extreme and uncontrollable circumstances hardship exceptions to others. However, for clinicians who are currently on the front lines throwing all of their resources and energy behind fighting this epidemic, asking clinicians to fill out a form and apply for these exceptions adds unnecessary administrative burden at a time physician practices cannot afford it. Hardship exceptions should be applied automatically. CMS can simply apply the automatic exception, or use submitted data if it yields a more advantageous score as they do with facility-based scoring, as it seems impractical to penalize clinicians for submitting data when a waiver is widely available. CMS should continue doing everything in its power to encourage the reporting of data, especially in these difficult circumstances. Importantly, CMS also should extend protections to the 2020 performance year immediately.

- 2. Hold Advanced APM participants harmless from risk-based payments for the 2020 performance year. At a minimum, offer participants the option to mitigate downside risk in exchange for reduced upside risk, and reassure participants they will continue to share in savings generated.**

Physicians and their practices participating in Advanced APMs have completely restructured the way they deliver care that in many ways makes them uniquely able to serve in times of crisis like this. This sort of wholesale innovation requires a substantial amount of upfront and ongoing investment to support the necessary health IT, personnel, and quality analytics infrastructure, which the participants in these models rely on model payments like shared savings payments to fund. Right now, many practices are not certain they can financially survive this PHE. Without support in this time of immense strain on resources, a large majority of Advanced APM participants, particularly those in risk-bearing APMs, will simply not be able to sustain the costs it takes to participate in these innovative delivery models in the first place, much less the financial risk they entail. According to a [recent poll](#) by the National Association of Accountable Care Organizations (ACOs), over half of risk-bearing Medicare Shared Savings Program ACOs are actively considering dropping out of the program. ACP sincerely appreciates CMS' [recent announcement](#) making much-needed accommodations to the Medicare Shared Savings Program (MSSP), including adjusting benchmarks to account for treating patients with COVID-19 and allowing ACOs the option to continue in their current contracts and/or risk levels in 2021. These will provide much needed protections, as ACOs in many ways lead the charge for providing a comprehensive, coordinated response to this crisis. However, ACOs still need additional protections from downside risk and these types of protections must be expanded to participants in all types of APMs, particularly those that bear risk. ACP believes that such action is necessary to ensure the future viability of the value-based movement in the face of such an unprecedented crisis. If CMS does not act quickly, we risk losing a substantial amount of the hard work, investment, and progress gained under the value-based payment reform movement, particularly risk-bearing APMs, that will

far outweigh these short-term concessions in the end. Many Advanced APMs have multi-year contract agreements, so the setback will be felt for years to come.

**3. Extend key participation deadlines, delay scheduled advances to higher risk tracks, and offer contract extensions.**

Physicians are hungry for new APMs. However, with all hands on deck dealing with the COVID-19 crisis, many do not have the bandwidth to perform the necessary cost-benefit calculations and make major decisions such as entering into a new APM in the next few months. They need time for the dust to settle and ideally, for their financial reserves to recover. Delaying participation agreement deadlines for the Primary Care First (PCF) and Direct Contracting Models will be critical to successfully soliciting a robust introductory class of participants. For some, this experience dealing with the unpredictability and other repercussions of the COVID-19 PHE may be an added incentive to transition out of the fee-for-service structure. Models that offer per member per month payments like PCF may be particularly attractive. However, practices simply do not have the capacity to make that decision in the coming months and need more time. ACP very much appreciates CMS' decision to allow MSSP ACOs the option to extend their existing agreement periods by one year if expiring in 2020 and remain in their current level of participation in the BASIC track. Flexibilities like this are exactly the types of support ACOs and other APM Entities will need in order to weather this crisis and continue participation in Advanced APMs. At the same time, ACP does not support the decision to cancel outright the 2021 MSSP solicitation cycle. Historic benchmarks are based on three years of data, so CMS will need to devise adjustments to account for the impact of COVID-19 in any case. CMS should be supporting and encouraging clinicians to transition to APMs more than ever, not removing opportunities to join existing and new APMs.

**In Conclusion**

ACP is appreciative and continues to be encouraged by the actions taken by CMS to help physicians and their teams in both caring for patients who are being treated for COVID-19 and patients at-large. The changes we recommend will provide an immediate sense of relief so that our frontline clinicians can devote all of their energy towards battling the spread of this disease. It will also lay the necessary groundwork as we begin to uncover the full impact of this pandemic and explore additional policy solutions to continue to support our nation's clinicians in the months and years to come. ACP offers our assistance toward these efforts. Please contact Brian Outland, PhD, Director, Regulatory Affairs, by phone at 202-261-4544 or email at [boutland@acponline.org](mailto:boutland@acponline.org) if you have questions or need additional information.

Sincerely,

A handwritten signature in black ink that reads "Jacqueline W. Fincher". The signature is written in a cursive, flowing style.

Jacqueline W. Fincher, MD, MACP  
President