American College of Physicians
Leading Internal Medicine, Improving Lives

June 11, 2020

Michael F. Consedine
Chief Executive Offier
National Association of Insurance Commissioners
444 N. Capitol Street NW Suite 700
Washington, DC 20001

Dear Mr. Consedine:

On behalf of the American College of Physicians (ACP), the largest medical specialty organization and the second largest physician group in the United States, I am writing to share ACP's recommendations to the National Association of Insurance Commissioners (NAIC) regarding telehealth and regulatory flexibilities that will need to remain in place for an extended period after the Coronavirus Disease 2019 (COVID-19) national public health emergency (PHE) has lifted. ACP members include 159,000 internal medicine physicians (internists), specialists, and medical students dedicated to scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

Since our last letter, physician practices are stretched to their financial and resource limits and are struggling to keep their doors open after battling this crisis for several months and facing an unprecedented drop in patient volume and revenue.[1] Now more than ever, clinicians need support, particularly financial support.

The College urges NAIC to call on all insurers for immediate:

1) Full payment parity for telehealth services and audio-only services relative to in-person E/M visits;
2) Compensation to counteract the unparalleled drop in revenue including reimbursing waived patient copays and instituting direct relief payments;
3) Development of Alternative Payment Models that move away from inconsistent fee-for-service (FFS), particularly those that offer fixed, periodic prospective payments; and
4) Relief from burdensome coding and documentation requirements, including prior authorization requirements.

Despite financial support from federal and state governments, at the end of May 45% of practices reported staff furloughs or layoffs, 28% reported deferred salaries, and 14% had temporarily closed, inhibiting patient access to care.[2] According to a new report from FAIR Health, from April 2019 to April 2020, utilization of professional services fell 68% and revenue is down 48%.[3] If private payers do not join with the Centers for Medicare & Medicaid Services (CMS) to provide physician practices with the critical support they need in this unprecedented crisis, hundreds if not thousands of practices across the country may be at real financial risk of closing, leaving a critical shortage of healthcare services at a time we can least afford it.

[1] "National Income and Product Accounts: Table 1.5.1 Percent Change From Preceding Period in Real GDP, Expanded Detail." Bureau of Economic Analysis. Last revised May 28, 2020: apps.bea.gov/iTable/iTable.cfm.
[2] Primary Care & COVID-19: Week 11 Surveys. Primary Care Collaborative. May 27, 2020. https://www.pcpcc.org/2020/05/26/primary-care-covid-19-week-11-surveys.
[3] Healthcare Professionals and the Impact of COVID-19. A Comparative Study of Revenue and Utilization. June 10, 2020. https://s3.amazonaws.com/media2.fairhealth.org/brief/asset/HealthcareProfessionalsandtheImpactofCOVID-19-ComparativeStudyofRevenueandUtilization-FAIRHealthBrief.pdf.

I. Telehealth, Telephone, and Remote Patient Monitoring Services (RPM)

Many payers have taken steps to address the need for telehealth solutions during this pandemic, which are welcome and necessary to allowing patients to continue receiving critical medical services while ensuring their own personal safety and preventing further spread of COVID-19. Specifically, ACP appreciates efforts by payers to reimburse telehealth visits at the same rate as in-person visits, including for audio-only services. Unfortunately, full payment parity is the exception and not the norm, particularly when it comes to audio-only services, which is a problem when nearly three in ten patients do not have access to broadband to support most digital care platforms.[4] Plans are also restricting coverage to certain types of services, reimbursing services furnished via telehealth at lower rates than they otherwise would, or restricting parity to in-network clinicians, which have become increasingly narrow and in some cases, consolidated under the payer's direct ownership.[5] It is also unclear in many cases whether payers who do reimburse telehealth services are doing so for new patients, as well as established patients, as CMS has done. Others do not cover audio-only services or limit coverage for telehealth to select, often proprietary platforms. This is extremely problematic; these approaches can prevent patients from interacting with their personal clinicians, thus interfering with ongoing patient-physician relationships and leading to fragmented care. These relationships are the underpinning of continuous and coordinated care, particularly for patients with multiple chronic conditions who most need to socially distance from physician practice settings—and in some cases, from their own family members—to protect themselves from exposure to the virus while receiving uninterrupted care services. **ACP urges NAIC to call on all plans to develop and adopt uniform policies that reimburse all services furnished via telehealth and audio-only taking place between patients and their own physicians on par with in-person services for both new and established patients.** Practices are struggling to keep their doors open during this pandemic; time spent monitoring for constant updates on individual payer policies is time that could be devoted to direct patient care or slowing spread of the disease. **NAIC should direct plans to allow the use of public facing video platforms such as Skype and FaceTime to provide patients and physicians with more options to ensure effective and efficient virtual care during, and ideally beyond, the PHE.** To ensure continuity of care, telehealth and telephone services should be available through readily accessible technologies to patients and their clinicians, not proprietary insurer platforms.

Patient access to RPM services also is critically important in order to maintain patient safety and slow the spread of COVID-19. The College strongly supported CMS' recent decision to expand access to RPM services by allowing physicians to bill them for both new and established patients, as well as acute and chronic conditions, and to allow patients to consent to these services once annually. **NAIC should implore private payers to emulate these recently finalized CMS flexibilities for RPM services.**

Many existing flexibilities and policy changes are set to expire at the conclusion of the PHE, wherein patients and physician practices would be expected to revert to primarily face-to-face services without any type of risk-based assessment for gradually reopening medical practices and health systems to care for non-COVID and non-acute patients.[6] Practices have made significant adjustments to their delivery structure in light of the crisis, such as investing in and shifting to an infrastructure that is much more dependent on telehealth and audio-only visits, and RPM services. This has evolved into the "new normal" for the practice and delivery of

[4] Primary Care & COVID-19: Week 11 Surveys. Primary Care Collaborative. May 27, 2020. https://www.pcpcc.org/2020/05/26/primary-care-covid-19-week-11-surveys.

[5] Weigel G, Ramaswamy A, Sobel L, et al. "Opportunities and Barriers for Telemedicine in the U.S. During the COVID-19 Emergency and Beyond." Kaiser Family Foundation. Published May 11, 2020: https://www.kff.org/womens-health-policy/issue-brief/opportunities-and-barriers-for-telemedicine-in-the-u-s-during-the-covid-19-emergency-and-beyond/.

[6] Doherty R, Erickson S, Smith C, Qaseem A. "Partial Resumption of Economic, Health Care and Other Activities While Mitigating COVID-19 Risk and Expanding System Capacity." American College of Physicians, May 6, 2020: 2.

medicine. To reverse these policies and revert to a reimbursement structure that centers on in-person services is not an effective way to recover from this crisis, nor to prepare for future potential outbreaks. Therefore, **ACP recommends that NAIC encourage payers to consider making many of these changes permanent. At a minimum, these changes should extend at least through the end of 2021, or until such a time when effective vaccines and treatments are widely available, with an option to extend further based on the experiences of patients and physicians.**

II. Patient Cost Sharing

ACP appreciates that many payers have offered patients critical relief from copays and cost sharing for certain services, including telehealth and those related to testing and treatment for COVID-19. At a time when the country is facing the highest unemployment rate since the Great Depression,[7] these policies are critical to getting patients the treatment they need and preventing further spread of the disease. Unfortunately, the vast majority of payers are not making up the difference to practices, leaving them to absorb another 20% loss when they are already facing revenue shortfalls of up to 55%.[8] These policies are also inconsistent across payers, with wide variation in the types of services they cover and when these policies are set to expire. Many cost sharing support policies are restricted only to patients formally diagnosed with COVID-19, despite the well-established under-reporting of cases,[9] or in the case of telehealth services, those furnished by select, often proprietary, technology platforms. Others apply to in-network clinicians only. **ACP recommends NAIC direct plans to establish consistent policies that allow clinicians to waive patient cost sharing for COVID-19-related testing and treatment, primary care services, and telehealth and telephone services. Importantly, payers should also be expected to pay the difference for all waived patient cost sharing to protect practices from further revenue losses. These policies should last at least through the end of 2021, with an option to extend further as needed to ensure continued beneficiary access to care.**

III. Direct Relief Payments

ACP has heard from many internal medicine specialists providing primary and comprehensive care to patients that they are just weeks away from closing their doors due to drastic declines in patient volume. Only 47% of practices have enough cash on hand to stay open four more weeks.[10] Additionally, the COVID-19 pandemic has shown the inherent flaws of fee-for-service (FFS) as a way of compensating physicians, particularly primary care physicians. Even as in-office visits begin to resume, we anticipate that reduced patient volumes and associated revenue losses will continue at least through the end of 2021. COVID-19 mitigation strategies will require that clinicians continue to space out in-person appointments and see fewer patients per day. Many patients will also be reluctant to come into the office for care. While telehealth payment parity policies help to cover some of this shortfall, they do not begin to cover the full scope of losses.

We recognize and appreciate that the U.S. Department of Health and Human Services (HHS) made general distributions to physicians and hospitals out of the Provider Relief Fund (PRF) created by the Coronavirus Aid, Relief, and Economic Security (CARES) Act and that Congress provided an additional $75 billion in funding for hospitals and physicians through the Paycheck Protection Program and Health Care Enhancement Act.

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[7] "The Employment Situation: April 2020." Bureau of Labor Statistics, U.S. Department of Labor. Published May 8, 2020: https://www.bls.gov/news.release/pdf/empsit.pdf.

[8] "COVID-19 Financial Impact on Medical Practices." Medical Group Management Association. Published April 8, 2020: https://www.mgma.com/COVID-Financial-Impact-One-Pager-8-5x11-MW-2.pdf.aspx?lang=en-US&ext=.pdf.

[9] "Excess Deaths Associated with COVID-19." National Center for Health Statistics, Centers for Disease Control and Prevention. Last revised May 27, 2020: https://www.cdc.gov/nchs/nvss/vsrr/covid19/excess_deaths.htm.

[10] "Primary Care & COVID-19: Week 5 Survey." Primary Care Collaborative. Published April 17, 2020: https://www.pcpcc.org/2020/04/16/primary-care-covid-19-week-5-survey.

However, such disbursements are not sufficient to keep many practices from closing. The general allocations also require that primary care and internal medicine subspecialists compete for limited funding and often come up short, leaving many primary care needs unmet. Private payers must do their own part to provide practices with the critical funding support they need to weather this crisis.

ACP urges NAIC to call on private payers to rise to the occasion by making their own direct relief payments to primary care physician practices, internal medicine subspecialty practices, small practices, and practices serving underserved communities, retroactively to April 1 through the end of the calendar year. The College makes this ask of private payers in parallel with our ask to HHS to establish a targeted allocation out of the PRF to primary care physician practices, similar to the targeted allocation for rural hospitals, that is sufficient to offset at least 80% of total lost revenue from all public and private payers from April 1 through at least the end of the calendar year. Allocation amounts should take into account disbursements already received by such practices from the general PRF allocations. **Private payers should work with Medicare and Medicaid to ensure that together they provide the necessary support practices need to keep their doors open, rather than being forced to close or sell to equity firms or large consolidated health care systems, which will ultimately drive up health care costs and reduce access to care.**

IV. Value-Based Payment Opportunities

The existing cracks of the FFS infrastructure have been exacerbated and exposed by the pressures of the COVID-19 pandemic.[11] This crisis has underscored the urgency with which innovative value-based alternatives must be developed. **The College is calling on NAIC to direct payers to create more opportunities for primary care and internal medicine specialty physician practices to transition away from FFS by expanding existing or expediting the development of new alternative payment arrangements. In particular, payers should look to develop models that offer fixed, periodic prospective payments such as PMPM payments that will give healthcare systems the financial consistency needed to build the necessary population management infrastructure to more effectively deal with future health crises.** Importantly, these new financial models should provide both up-front funding and reinsurance options and offer clinicians a variety of financial risk levels including low to no risk options, particularly in the near term as practices recover from the financial and infrastructure shock of dealing with this crisis.

Equally important, clinicians currently participating in value-based arrangements must be assured they will not be penalized for adverse quality or utilization outcomes that directly result from the COVID-19 PHE. Not doing so risks undercutting clinician willingness to participate in future value-based reforms and subjects practices to further payment cuts they cannot afford to absorb based on compromised data. **NAIC should prevent payers from using 2020 data as a basis for assessing performance-based penalties or making network determinations.** Additionally, payers should agree not to post 2020 quality and cost data for public consumption and not use this data to inform measure thresholds, financial benchmarks, risk adjustment, or patient attribution for future performance years, given the largescale impact of COVID-19.

V. Relief from Administrative Burden

ACP appreciates the steps taken to curb administrative burden during this critical time including streamlining credentialing processes, offering temporary reprieve from prior authorization requirements for COVID-19 related testing and treatment and/or transitions to post-acute care settings, and extending timeframes for documentation requirements. Taken together, these changes will help to expedite treatment of COVID-19 patients and free up medical resources and staff to treat more urgent cases. However, many of these policies

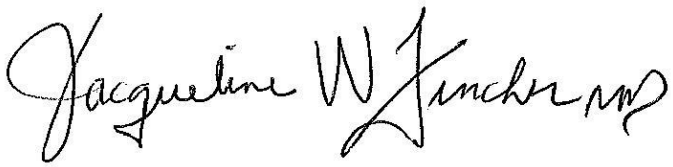
[11] "Primary Care & COVID-19: Week 3 Survey." Primary Care Collaborative. Published April 1, 2020: https://www.pcpcc.org/2020/04/01/primary-care-covid-19-week-3-survey.

are restricted to COVID-19 patients or certain types of services. Many COVID-19 cases go unreported, which means a large number of patients and services will be subject to wait times during critical windows that puts the patient's own health in jeopardy, as well as those around them. Additionally, satisfying prior authorization requests places a major strain on practice resources and staff time, both of which are in critical supply during the COVID-19 PHE. On average, medical practices spend two days per week per physician on prior authorization requests.[12] Providing even temporarily relief from burdensome prior authorization and other documentation requirements not just for COVID-19 patients, but all patients, during this critical time would allow physicians to devote more of their limited time and resources toward treating patients and stopping the spread of COVID-19. **NAIC should call on payers to waive all prior authorization requirements and ease documentation requirements for <u>all</u> patients (not just COVID-19 patients) for the duration of the COVID-19 PHE and immediate recovery period, at least through 2021 or until such a time when effective vaccines and treatments are widely available, with an option to extend further or make permanent based on learned experience.** ACP also reiterates its previous recommendations to emulate recent finalized changes to Medicare clinician enrollment and credentialing and E/M coding so clinicians can rely on a uniform set of rules during this time of crisis.

In Conclusion

ACP is encouraged by the actions taken by payers to date that will enable physicians and their teams to safely treat COVID-19 patients and prevent further spread of the disease while continuing to care for the rest of their patients in a way that minimizes risk for everyone. At the same time, more can and needs to be done. ACP is calling on NAIC to serve as a leader during this time of crisis and call on payers to step up and provide struggling practices with the financial support and administrative relief they need to focus on treating their patients and surviving this pandemic. This support must include reimbursing practices for waived patient copays and following CMS' lead to institute direct relief funds. The recovery will be gradual and take place over the course of several years, not days. It is critical that payers continue this support not just during the immediate PHE, but also over the full recovery period, at least through the end of 2021, with an option to extend further or make some or all of the changes permanent. As the untold impact of this pandemic continues to unfold, ACP would like to offer our assistance as we continue to support medical practices through the immediate crisis and begin the rebuilding process. Please contact Suzanne Joy, Senior Associate, Regulatory Affairs, at 202-261-4553 or sjoy@acponline.org with questions or for additional information.

Sincerely,



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[12] "2017 AMA Prior Authorization Physician Survey." American Medical Association. Published February 2018: https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc/prior-auth-2017.pdf.