



April 28, 2020

The Honorable Alex Azar  
Secretary  
Department of Health and Human Services  
200 Independence Avenue, NW  
Washington, D.C. 20201

Dear Secretary Azar:

On behalf of the American College of Physicians (ACP), I am writing to share our recommendations on additional steps that should be taken by HHS and CMS to support physicians and their practices during the unprecedented public health emergency (PHE) caused by the COVID-19 pandemic. While we greatly appreciate the actions already taken by both HHS and CMS to disburse funding to practices, we believe more must be done to help support and sustain physicians and their practices.

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.

The initial distribution of \$30 billion from the Provider Relief Fund, and the recently-announced plans by HHS to distribute additional monies to physicians and hospitals out of the \$100 billion from the CARES Act, has and will be of help to many struggling practices. ACP is also pleased to see an additional \$75 billion allocated by Congress for the Public Health and Social Services Emergency Fund (PHSSEF). However, ACP is concerned that such disbursements may not be sufficient to offset the losses of revenue experienced by physicians and their practices needed to keep their doors open, unless HHS takes specific actions now to prioritize practices as recommended below.

**Specifically, ACP recommends that a substantial and dedicated portion of the newly authorized \$75 billion of the PHSSEF be rapidly and automatically disbursed to physicians and their practices based on lost revenue and increased costs.** Such lost revenue and increased costs could be determined by physicians attesting to: (1) additional expenses incurred by a practice related to COVID-19, for example additional staffing, infrastructure, temporary re-location of their place of residence to prevent exposing family members to the virus, and supply costs, and (2) the percentage of revenue losses from all payers (Medicare, Medicaid, commercial insurers) resulting from the decline of in-person care visits during this crisis that will not be recouped.

**In addition, ACP recommends that a substantial portion of PHSSEF disbursements be set aside and expressly prioritized to support and sustain:**

1. **Primary care physicians and their practices.** Internal medicine specialists and other primary care physicians have an essential role in delivering primary, preventive, and comprehensive care not only to patients with symptoms or diagnoses of COVID-19, but also to patients with other underlying medical conditions, including conditions like heart disease and diabetes that put them at greater risk of mortality from COVID-19. Many studies have shown that the availability of primary care in a community is associated with reduced preventable mortality and lower costs of care, yet recent surveys suggest that many will soon close without additional support<sup>1</sup>.
2. **Internal medicine subspecialists and their practices.** Internal medicine subspecialists are essential in the diagnose, management, and treatment of patients with the most complex chronic illnesses, including conditions that put patients at the highest risk of mortality from COVID-19, as well as patients with other complex conditions whose health and lives depend on care from internal medicine subspecialists. Many internal medicine subspecialty practices are at high risk of closing due to lost revenue.
3. **Physicians in smaller practices** (e.g. 15 or fewer physicians), especially primary care physicians in smaller practices. Smaller practices lack the resources to stay open with substantially lower revenues and often do not have the administrative staff to apply for loans and other forms of assistance.
4. **Physicians and practices in underserved rural and urban communities**, including practices that treat patients at higher risk because of social determinants of health and racial, ethnic, and other personal characteristics. The experience with COVID-19 suggests many patients are at higher overall risk of mortality and morbidity due to social determinants and racial and ethnic characteristics, particularly for African-Americans. Such patients are more likely to be found in underserved communities. It is essential to keep the practices that care for them open.
5. **Physicians and practices that fall into two or more of the above categories for prioritization, e.g. primary care physicians in smaller practices, and/or who practice in underserved communities.**

In addition, ACP specifically recommends that HHS set aside a specific dollar amount out of PHSSEF funding **expressly dedicated to making primary care physicians and their practices whole for any lost revenue and increased expenses due to COVID-19, at least through the end of this calendar year, through a prospective per patient per month (PPPM) payment.**

COVID-19 has illustrated the flaws of paying primary care physicians predominantly on a fee-for-service (FFS) basis, because as they have moved away from in-person visits, they no longer are getting the “fee” associated with the office visit service, while the “fee” for telehealth and audio-only phone calls has not been sufficient to offset the loss of revenue from in-person visits. Distributing PHSSEF disbursements to primary care physicians and their practices through a PPPM methodology would provide them with the revenue and support needed to keep their practices open at this difficult time, without having to depend on a flawed FFS system that is unlikely to provide them the support needed and make them whole for lost revenue.

We recommend that HHS consider ways to determine and disburse PPPM prospective payments to primary care physicians based on data that is already available to HHS/CMS and from primary care programs supported by the Center on Medicare and Medicaid Innovation (CMMI).

One promising approach was developed by the Commonwealth Fund and the Milbank Memorial Fund, which recommends that sizeable, supplemental, prospective payments to primary care physicians and practices be made available for the next 12 months through a PPPM (\$50-\$70) prospective payment, adjusted for patient demographics. Patients would be “attributed to practices via established CMMI methodology and payments for Medicare Advantage patients could be paid directly by CMS. CMMI is a vehicle through which the resources could be distributed.” They further recommend that HHS/CMS “allow retainer payments in Medicaid (similar to Medicare), targeting providers where Medicaid is a predominant payer and attestation that they will maintain their staff. In addition, authorize supplemental, PMPM payments above the retainer payments (\$40-\$60 PPPM), adjusted for patient demographics.”

A similar approach would be to base the PPPM payments on the Comprehensive Primary Care Plus (CPC+) model. The CPC+ payment model offers the potential of greatly strengthening the ability of internists and other primary care clinicians in thousands of practices nationwide to be able to keep their doors open and deliver high-value, high-performing, effective, and accessible primary care to millions of patients. HHS could instruct CMS to expand the CPC+ payment model to allow primary care practices and internal medicine subspecialties the option to elect payment under the track 2 portion of the program for the remainder of 2020 for ambulatory, office-based, face-to-face, and telehealth evaluation and management (E/M) services.

Internal medicine specialists that perform primary care services would receive this population-based payment for each of their patients. Payment must not be based on how well the practice performed on patient experience of care measures, clinical quality measures, or utilization measures. Under the payment structure, the amount of the CPC payment would be determined by:

- (1) The number of beneficiaries attributed to a given practice per month based on the previous year’s historical Medicare claims to attribute beneficiaries to the practice by recency of Chronic Care Management (CCM) services, recency of Annual Wellness or Welcome to Medicare Visit, or plurality of eligible primary care visits for that beneficiary. FFS payment will be paid at an amount using the 2021 approved E/M RUV amounts.
- (2) The case mix of the attributed beneficiary population.

There may be other programs like the Primary Care First program that could be adapted by HHS to provide sustained and sufficient PPPM payments to primary care, starting as quickly as possible, to make them whole, or mostly whole, from any revenue losses and increased expenses resulting from COVID-19.

For any such PPPM payment methodologies, CMMI could evaluate the amounts and methods of payments to primary care by Medicare and Medicaid/CHIP as a percentage of total health care expenses and assess their effects on quality, costs, and community pandemic preparedness. If the effect of the prospective method is determined to be no worse than previous payment methods on quality, cost, and pandemic preparedness, CMS should implement these methods in the Medicare payment system.

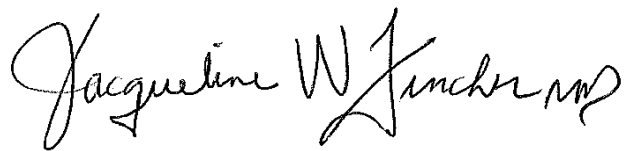
**Finally, ACP is concerned about the decision by CMS to suspend the Medicare Advance Payment Program.** This program, combined with other sources of potential revenue from the PSSPF disbursements, has been a lifeline to many practices. ACP has previously recommended that HHS and CMS extend the repayment period, and lower the interest rate to zero, for the Advance Payment

Program. It is inexplicable that CMS has decided instead to suspend it, and the rationale offered does not support suspending it. ACP strongly urges HHS and CMS to reinstate the Advance Payment Program and implement the changes that ACP has previously recommended to improve it.

We believe the actions recommended by ACP in this letter will complement those taken to date by the Agency and will further enable physicians to provide necessary care to those suffering from COVID-19, as well as their broader patient populations as needed and appropriate.

If you have any questions regarding this letter or would like to discuss the details further, please contact Brian Outland, Director, Regulatory Affairs at [boutland@acponline.org](mailto:boutland@acponline.org).

Sincerely,

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

Jacqueline W. Fincher, MD, MACP  
President  
American College of Physicians

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<sup>1</sup> [https://www.commonwealthfund.org/blog/2020/primary-care-and-covid-19-pandemic?utm\\_source=alert&utm\\_medium=email&utm\\_campaign=Delivery%20System%20Reform](https://www.commonwealthfund.org/blog/2020/primary-care-and-covid-19-pandemic?utm_source=alert&utm_medium=email&utm_campaign=Delivery%20System%20Reform)