American College of Physicians
Leading Internal Medicine, Improving Lives

June 11, 2020

David S. Wichmann
Chief Executive Officer
UnitedHealth Group
5901 Lincoln Dr.
Minneapolis, MN 55436

Dear Mr. Wichmann,

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 UnitedHealth Group 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, we have appreciated UnitedHealth's leadership and how it has stepped up to ease burdens on clinicians and expand reimbursement for telehealth and telephone services so that physicians can safely treat their patients while preventing the spread of COVID-19. In particular, we appreciate the nearly $2 billion in advanced payments and financial assistance, waiving of cost sharing for audio-visual telehealth and audio-only services, reimbursing clinicians for the patient cost sharing amount for Medicare Advantage plans, and waiving or easing numerous prior authorization requirements.

However, we are concerned that UnitedHealth is restricting full payment parity for telehealth and telephone services to propriety platforms. We have also heard about difficulties with applying for and receiving HHS provider relief funds that UnitedHealth is helping to distribute. After battling this crisis for several months, physician practices are stretched to their financial and resource limits and are struggling to keep their doors open due to an unprecedented drop in patient volume and revenue.[1] They are in desperate need of further support.

Specifically, the College is calling for:

1) An extension of telehealth and telephone flexibilities paid at full parity with in-person services regardless of the platform used;
2) Additional financial supports that do **not** require repayment, including reimbursing waived patient cost sharing responsibilities for all types of plans (not just Medicare Advantage plans) and 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) An extension and expansion of current administrative flexibilities, including a broad reprieve from prior authorization requirements.

[1] "National Income and Product Accounts: Table 1.5.1 Percent Change From Preceding Period in Real Gross Domestic Product, Expanded Detail." Bureau of Economic Analysis. May 28, 2020: apps.bea.gov/iTable/iTable.cfm=survey.

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.

I. Telehealth and Remote Patient Monitoring Services (RPM)

The steps undertaken by UnitedHealth to address the need for telehealth solutions during this pandemic 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. ACP applauds UnitedHealth allowing clinicians to bill for expanded telehealth services, including audio-only visits, waiving originating site requirements, and allowing popular applications with video functionalities to be utilized. However, ACP understands that UnitedHealth does not reimburse all services at full parity with in-person rates, particularly those delivered outside of UnitedHealth's own proprietary platforms. This is extremely problematic; these approaches can prevent patients from interacting with their own personal clinicians, thus leading to more fragmented care and interfering with ongoing patient-physician relationships. These relationships are the underpinning of continuous and coordinated care, particularly for patients that need to manage multiple chronic conditions and who most need to practice social distancing from physician practices and clinics—and in some cases, from their own family members—to protect themselves from exposure to the virus while receiving uninterrupted primary care services. During this time of crisis where practices are getting new telehealth and remote visit policies up and running virtually overnight to deliver care in a safe and effective manner, clinicians do not have time to navigate dozens of proprietary payer platforms or else face more cuts to their reimbursement. It is also unclear in many cases whether UnitedHealth is reimbursing audio-only and telehealth services for new patients, as well as established patients, as CMS has done. **ACP urges UnitedHealth to reimburse all services furnished via telehealth and audio-only on par with in-person services for both new and established patients, including those using non-public facing synchronous video platforms, such as Skype and FaceTime. To ensure continuity of care, telehealth and telephone services must be available through readily accessible technologies to patients and their clinicians, not proprietary insurer platforms.**

ACP applauds UnitedHealth for expanding access to RPM services and its stated commitment to follow CMS guidelines. We ask UnitedHealth to clarify that it will follow CMS' recent decision to allow physicians to bill them for both new and established patients, as well as acute and chronic conditions. These important changes will enable physicians and their care teams to adapt to the new environment and deliver patients the care they need in a manner that helps to protect their safety, as well as those around them.

ACP appreciates that UnitedHealth recently extended many of these benefits through September 2020. As discussed earlier, 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, as well as RPM services. 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. **ACP urges UnitedHealth to consider making these changes permanent. At a minimum,**

[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.

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 learned experience.

II. Patient Cost Sharing

ACP commends UnitedHealth for waiving patient cost sharing for in-network telehealth services through September 30, for the testing and treatment of COVID-19 until July 24, and for all office-based professional services performed by both primary care physicians and specialists until at least September 30 for Medicare Advantage (MA) plan members. At a time when the country is facing the highest unemployment rate since the Great Depression,[4] these policies will help to get patients the treatment they need and preventing further spread of the disease. **We urge UnitedHealth to extend patient cost sharing flexibilities through at least the end of 2021, with an option to extend further as needed to ensure continued beneficiary access to care.** ACP applauds UnitedHealth for reimbursing clinicians for cost sharing amounts they would have received for MA plans. However, this does not go far enough. **We call on UnitedHealth to reimburse cost sharing all of its beneficiaries, not only those in MA plans, for the duration that these cost-sharing provisions are in place.** Practices cannot absorb another 20% loss when they are already facing revenue shortfalls of up to 55%.[5]

III. Direct Relief Payments

ACP commends UnitedHealth for providing nearly $2 billion in accelerated payments and other financial support to clinicians, including up to $125 million in small business loans. These critical funding sources will help physician practices immediately weather historic revenue declines. It is important use of these funds not be burdened with confusing application or excessive documentation requirements, as has been an issue with federal emergency payments.[6] It is also important UnitedHealth provide clinician practices with sufficient time to reconcile or repay advance payments. Practices are still in crisis mode and will be rebuilding for many months after the PHE has technically concluded. **Repayments should not be due until 2022 at the earliest.**

While these up front funding supports are immensely important, more must be done. 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. Even as in-office visits begin to resume, we anticipate that reduced patient volumes and associated revenue losses will continue through at least 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 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. Only 47% of practices have enough cash on hand to stay open four more weeks.[7]

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. Unfortunately, ACP has received numerous reports of the difficulties applying for and receiving these payments, which we understand UnitedHealth is helping to distribute. **Therefore, we urge UnitedHealth to be**

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[4] "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.

[5] "COVID-19 Financial Impact on Medical Practices." Medical Group Management Association. Published April 8, 2020: https://www.mgma.com/getattachment/COVID-Financial-Impact-One-Pager.pdf.

[6] Berg, Sara. "Dirty Dozen: The 12 Factors that Drive Physician Burnout." AMA. Published May 28, 2020: https://www.ama-assn.org/practice-management/physician-health/dirty-dozen-12-factors-drive-physician-burnout.

[7] "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.

more transparent about their role in dispensing PRF payments to practices and provide more clear guidance on how to apply and receive these payments, and any future similar payment assistance from HHS.

In addition, ACP calls on UnitedHealth to make direct relief payments to primary care physician practices, internal medicine subspecialty practices, small practices, and practices serving underserved communities that would not have to be reconciled or paid back, retroactive 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 for the same timeframe. Allocation amounts would 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 patient access to care.**

IV. Value-Based Payment Opportunities

The existing cracks of the FFS infrastructure have become exacerbated and exposed by the pressures of dealing with COVID-19 crisis.[8] FFS has proven to be an ineffective infrastructure for efficiently delivering population-level health, particularly in times of crises. Practices face severe revenue shortfalls due to an unprecedented drop in patient volumes at the very time they most need additional financial resources to effectively treat the influx of COVID-19 patients along with their regular patients while preventing further spread of the disease. This crisis has underscored the urgency with which innovative value-based alternatives must be developed. **ACP urges UnitedHealth to create more opportunities for primary care and internal medicine specialty physician practices to transition away from FFS by expanding existing APMs 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 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. ACP appreciates UnitedHealth's decision to accelerate payments where possible.

Equally important, clinicians currently participating in existing value-based arrangements must be assured they will not be penalized for adverse quality or cost 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 based on compromised quality and cost data. **UnitedHealth should not use 2020 data as a basis for assessing performance-based penalties or making network determinations.** Additionally, UnitedHealth 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 UnitedHealth has taken to curb administrative burden during this critical time, which include suspending or relaxing prior authorization requirements for certain items and services, suspending site of service reviews, extending timely filing deadlines, easing certain credentialing requirements,

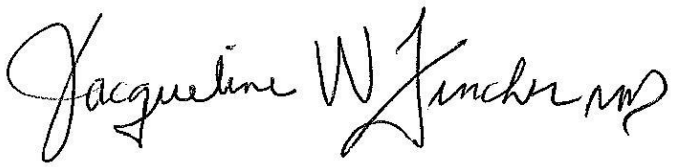
[8] "Primary Care & COVID-19: Week 3 Survey." Primary Care Collaborative. Published April 1, 2020: https://www.pcpcc.org/2020/04/01/primary-care-covid-19-week-3-survey.

and extending current prior authorizations by 90 days. These flexibilities will help to expedite treatment of COVID-19 patients and free up medical resources and staff to treat more urgent cases. ACP also appreciates that some of these flexibilities are extended to all patients, not just those diagnosed with COVID-19. 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. In addition, 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.[9] Providing even temporarily relief from burdensome prior authorization and other documentation requirements during this critical time could allow physicians to devote more of their limited time and resources toward treating patients and stopping the spread of COVID-19. **ACP calls on UnitedHealth to broaden all COVID-19 related administrative flexibilities to all patients (not only those diagnosed with COVID-19) 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 reiterates our prior recommendations to emulate recent finalized changes to Medicare clinician enrollment and credentialing and evaluation and management coding so clinicians can rely on a uniform set of rules and guidelines during this time of crisis.

In Conclusion

ACP is encouraged by the actions taken by UnitedHealth 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 UnitedHealth to serve as an example during this time of crisis and step up to provide struggling practices with the financial support and administrative relief they need to be able to devote all their resources toward treating and surviving this pandemic. This support must include reimbursing practices for **all** waived patient copays, not only for MA plans, and following CMS' lead to institute direct relief funds with no repayment required. The recovery will be gradual and take place over several years, not months. It is critical that UnitedHealth 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 full 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,



Jacqueline Fincher, MD, MACP
President
American College of Physicians

[9] "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.