American College of Physicians
Leading Internal Medicine, Improving Lives

April 13, 2020

The Honorable Nancy Pelosi
Speaker
United States House of Representatives
Washington, DC 20515

The Honorable Mitch McConnell
Majority Leader
United States Senate
Washington, DC 20510

The Honorable Kevin McCarthy
Minority Leader
United States House of Representatives
Washington, DC 20515

The Honorable Charles Schumer
Minority Leader
United States Senate
Washington, DC 20510

Dear Speaker Pelosi, Minority Leader McCarthy, Majority Leader McConnell, and Minority Leader Schumer:

On behalf of the American College of Physicians, I am writing to share our recommendations for additional legislation to sustain the health care and economic needs of our nation during this national emergency caused by the COVID-19 global pandemic. We are greatly appreciative that Congress has enacted three major pieces of legislation to address this unprecedented public health crisis, which includes numerous programs to help support and sustain physicians and their practices, begins to provide desperately needed personal protective equipment (PPE) to frontline physicians, nurses and other health care workers; increases health capacity; and expands access to affordable testing and treatment. These programs are beginning to make a very positive difference for physicians and their patients.

Yet more still needs to be done. We are encouraged that House and Senate leaders foresee an urgent need to pass additional stimulus/COVID-19 measures. As House and Senate leaders work together to draft legislation to respond to the COVID-19 crisis, we urge them to focus on the following priorities:

- Ensure the financial viability of physicians on the front lines of treating patients diagnosed with COVID-19.
- Reduce administrative burdens that may delay care for patients during this time; ensure access to health care coverage and treatment for the uninsured.
- Ensure that our physicians and health care professionals have access to personal protective equipment to shield them from harm.
- Expand coverage.

- Expand health system capacity.

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.

Specifically ACP recommends that the next COVID-19 stimulus legislation considered by Congress includes the following measures.

1. **Increase funding for the Paycheck Protection Program and direct the Small Business Administration to prioritize making loans available to physician practices.**
   We are pleased that the final version of the Coronavirus Aid, Relief, and Economic Security (CARES) Act that was signed into law included a Paycheck Protection Program (PPP) that will provide businesses with fewer than 500 employees the ability to cover payroll costs with up to a $10 million fully guaranteed loan at one percent in order to keep workers paid and employed. Businesses that maintained their payroll may also be allowed to receive loan forgiveness on a paycheck protection loan over an eight-week period in order to rehire workers who were furloughed. We urge Congress to:

   a. **Provide additional funding for this program as soon as possible to ensure that all small businesses qualified to receive these loans will receive the funds needed to sustain their business, including physician practices.** Congress authorized $349 billion in forgivable loans to sustain small businesses during this crisis. Recent reports indicate that this funding will soon be exhausted leaving eligible small businesses without access to the loans that they need. These loans will ensure that employees of small businesses will remain on the payroll as well as maintain their health insurance if their employer offers health insurance benefits. We are encouraged that House and Senate leaders are considering adding at least $250 billion more in funding for this program in the next COVID-19 stimulus bill.

   b. **Ensure effective implementation so that physician practices can readily qualify to receive these loans.** Our physicians have experienced a substantial decline in income over the last few weeks since they no longer see most of their patients in their office. While some of the programs created by the CARES Act and the decisions that the Centers for Medicare and Medicaid Services (CMS) has made to support physicians and their practices--such as partially paying for some phone calls and disbursing emergency funding to them--will certainly help, many still will not be able to survive a continued decline in practice revenue without more support. We know that many other small businesses are in financial peril at this time and also in need of financial assistance but ask that the needs of physician practices be

prioritized because they are critical to testing, diagnosing and treating COVID-19 patients, as well as taking care of all of the other medical conditions that patients may have, through virtual visits in most cases. We are concerned by reports that physicians, on behalf of their practices, have been unable to apply for loans because of technical problems, lack of available funders, and other problems.

c. Include provisions to apply the same exception to physician practices with more than one location but with 500 employees or less per location as applies to the Accommodation and Food Services Industry. Otherwise, many physician practices with multiple locations will be ineligible for PPP loans.

2. Increase funding for the Public Health and Social Service Emergency Fund (PHSSEF) created by the CARES Act and direct the Department of Health and Human Services (HHS) to ensure that a substantial portion of this is prioritized to support physicians and their practices who have the greatest need, and who are especially critical to patient care during the COVID-19 public health emergency.

As noted above, without immediate and direct support, many practices may not be able to meet payroll and will be at risk of closing, at a time when they are needed most. Without a specific pool of money set aside for physicians and practices, they will end up competing with large health systems and hospitals, perhaps putting them at a disadvantage for receiving these funds. There must be sufficient funding available for *physicians and hospitals* so that one does not squeeze out the other. Both are playing critically important roles in addressing the COVID-19 emergency.

ACP is appreciative that CMS Administrator Seema Verma announced last week that $30 billion out of the $100 billion emergency grant fund in the CARES Act would be automatically distributed his week to physician practices and hospitals to offset their estimated losses in Medicare revenue. ACP has begun hearing from many of our members that the funds are showing up in their accounts, providing much needed help as practices struggle to meet payroll and stay open. ACP is particularly pleased that these funds are being automatically distributed to physician practices without requiring an application or repayment, as we have also recommended.

It is evident, however, that this immediate infusion of support for practices will not make them "whole" for months of current and future lost revenue to their practices. Many still will be at risk of closing their doors.

Accordingly, we ask that Congress:

a. **Substantially increase funding for the PHSSEF Fund and direct that at least 30 percent of it be set aside to support physicians and practices.** (30 percent is approximately the share of Medicare spending that currently goes to physician services, excluding prescription drugs).

b. **Direct HHS and CMS to prioritize this portion of the additional funding, as well as the remaining $70 billion left from the initial $100 billion in funding from the CARES Act, to primary care physicians, physicians in smaller practices, physicians practicing in underserved rural and urban communities, physicians taking care of Medicaid patients, and physicians providing care directly to COVID-19 patients as well as to patients with other underlying complex and chronic medical conditions, many of which would place them at greater risk should they acquire COVID-19.**

c. **Do everything possible to ensure that the administration continues to implement this fund in a way that ensures rapid disbursement of funds to financially distressed practices, prospectively and concurrently, without physician practices having to apply for such funding.**

3. **Provide interest free loans and other mechanisms, such as a 9/11-type COVID fund, for physician practices of all sizes to ensure that they can remain afloat to meet the demands of this crisis and the ongoing health care needs of all of their patients.**

Reimbursable expenses should include payroll costs and other overhead costs, as well as payments made to outside firms for billing and IT purposes, especially for those practices that are too small to maintain part/full-time staff for these functions.

a. **We specifically recommend that Congress include the provisions in the Immediate Relief for Rural Facilities and Providers Act (S.3559),** introduced by Senators Bennet and Barrasso, to provide an emergency, one-time grant for all physicians and ambulatory surgery centers equal to their total payroll from January 1 to April 1, 2019. The grant should also include all overhead costs.

4. **Mandate changes in Medicare and Medicaid payments to support physicians and their practices.**

We appreciate that the CARES Act suspends Medicare sequestration cuts to physicians and hospitals. Yet, more can and should be done **to specifically and directly support physician practices,** recognizing the increased costs and reduced revenue being experienced by physicians on the frontlines of caring for COVID-19 patients, and other physicians whose practices are under severe economic stress as they shift to virtual visits.

Congress should:

a. **Mandate a positive Medicare Physician Fee Schedule (MPFS) update comparable to those hospitals and other "providers" received in 2020.**

While the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 included modest positive payment updates in prior years, it left a six-year gap from 2020 through

2025 during which there are no annual updates at all. Congress could not have predicted that the first year without a positive payment update to the MPFS would come at the beginning of a public health emergency like the one that faces our nation today. Even before the pandemic, physician practices faced increasing costs and payments that did not keep pace with inflation. This is in contrast with hospitals other providers who continued to receive positive updates in 2020.

b. **Ensure that increases in Medicare payments for undervalued Evaluation and Management (E/M) Services--as included in the 2020 Medicare Physician Fee Schedule Final rule--are implemented on January 1, 2021 as required by the rule.** ACP is supportive of Congress waiving budget neutrality for the increases in E/M services as mandated by the final rule, *provided that implementation of such increases are not conditioned on waiving budget neutrality*.

The 2020 MPFS final rule includes changes to improve payments for Evaluation and Management Services that have long been undervalued by Medicare and other payers. These changes were developed through a multi-specialty advisory process that determined that the current relative value units for E/M services do not accurately reflect the relative physician work involved and should be increased. The same process recommended changes to reduce the amount of time and administrative burden that physicians must spend documenting each E/M service. CMS appropriately accepted these recommendations and incorporated them into the final rule, with a January 1, 2021 implementation date.

Such improvements are even more important to primary care physicians, and other physician specialties that provide mostly primary, comprehensive and cognitive care services, as they struggle to keep their practices open during the COVID-19 crisis. It will provide them with assurance that starting in 2021, they will receive a substantial increase in Medicare payments for their office visits to help them recover from the lost revenue from the changes they've had to make in their practices due to COVID-19. While waiving budget neutrality would appropriately ensure that the E/M increases are not funded by requiring across-the-board budget neutrality adjustments to the Medicare Physician Fee Schedule Conversion Factor as normally required by law, given the current extraordinary challenges all physicians are facing, *ACP would strongly oppose making the E/M increases conditioned on waiving such requirements*.

c. **Require Medicaid pay parity for all physicians, and especially for primary care and subspecialty care, retroactive to the declaration of the COVID-19 national emergency.** We strongly support the renewal of applying the Medicare payment rate floor to primary care services furnished under Medicaid and urge the this policy be included in the next COVID-19 response legislation. While we support pay parity for all specialties, we believe that at a minimum, pay parity should be restored for primary care specialties and related subspecialties, as called for in H.R. 6159, the Kids Access to Primary Care Act. This will ensure that primary care physicians and internal medicine and pediatric subspecialists are paid no less than they would be paid under Medicare for the duration of the COVID-19 public

health emergency. Such pay parity should last at least for the duration of the COVID-19 emergency, although we strongly believe it should be made permanent thereafter.

d. **Pay physicians and hospitals 110 percent of the Medicare rates for providing COVID-19-related treatment for uninsured persons.** With tens of millions of Americans at risk of losing their jobs and employer-based coverage, many will end up being uninsured. Many simply and understandable will be unable to afford their care especially for COVID-19. Such uncompensated care will further threaten the viability of physician practices and create barriers to care. Paying physicians and hospitals 110 percent of the Medicare rates for care of uninsured persons for COVID-19 will help practices stay open while making care more affordable and accessible for uninsured patients.

5. **Require that all payers including CMS cover and pay for audio-only telephone consultations between physicians and their patients, at the same rate as an established patient in-office visit.**

While virtual telehealth visits may be covered in many cases by insurers, the service requires equipment with both audio and video capability and do not include traditional audio-only phone calls with patients. Not reimbursing for telephone visits (99441-99443)—at a payment level on par with in-person visits—disproportionally affects physicians and practices taking care of elderly and underserved patients. Many of these patients are managing multiple chronic conditions, do not have smartphones, or may have a smartphone, but do not know how to use FaceTime or Skype. As physicians convert in-person visits to virtual ones, practices are experiencing huge reductions in revenue while still having to pay rent, meet payroll, and meet other expenses without patients coming into their practices. Requiring all payers to cover and reimburse physicians for audio-only telephone visits at the same rate as an established patient in-person visit (99212-99214), will ensure that patients without advanced video-sharing capabilities are able to get care virtually, while helping to sustain physician practices.

Additionally, telehealth and telephone visits should include payment for the Medicare annual wellness visit (G0438 and G0439 and the preventive medicine service visits (annual physicals new patients 99381 – 99387 and established patients 99391 – 99397).These visits are vital to the physician in determining the general status of a patient's health. The visit also gives the patient the opportunity to talk to the physician about any ongoing pain or symptoms that the patient may be experiencing or any other health concerns that patient might have. This allows the physician to detect at an early stage any concerning symptoms that may be address before escalating into a more serious condition.

6. **Direct CMS to improve the Advance Medicare Payment Program and extend the amount of time by which physicians would have to pay back Medicare for the advance payment.**

   We are pleased that CMS has delivered near $34 billion in the past week to the healthcare professionals on the frontlines battling the COVID-19 outbreak through an expansion of the Accelerated and Advance Payment Program created by the CARES Act to ensure physicians and suppliers have the resources needed to combat the pandemic.

   We appreciate that the statute postpones the start of recoupment from day one to day 120 after initial payment and allows up to 365 days for repayment. CMS has worked quickly to provide flexibility to physicians who need financial assistance. However, we have heard significant concerns about the ability of physician practices to repay this amount of money while patients remain at home and physicians delay non-essential procedures and visits to preserve protective equipment and slow the spread of the virus, and there are statutory fixes needed to help physician practices.

   To make the Accelerated and Advance Payment Program more effective, Congress should:

   a. **Postpone recoupment until 365 days after the advance payment is issued;**
   b. **Reduce the per-claim recoupment amount from 100 percent to 25 percent ;**
   c. **Extend the repayment period for physicians to at least two years;**
   d. **Waive the interest that accrues during the extended payment period; and**
   e. **Give HHS authority to issue more than one advanced payment.**

7. **Require that CMS suspend Medicare preauthorization requirements for the duration of the emergency.**

   ACP recommends that Congress direct CMS to waive all prior authorization (PA) requirements during this period of national emergency, and urge Medicare Advantage organizations that contract with CMS to waive PA requirements as well. Delays in patient care resulting from PA restrictions may result in patients occupying hospital beds that could be used during this emergency. ACP appreciates the agency's work on efforts to reduce physician burden, and we urge CMS to allow additional flexibilities so that physicians may focus on patients, not paperwork.

   These administrative obstacles imposed by prior authorizations have become even more problematic given the current COVID-19 national emergency when frontline physicians need to focus their time and resources on curtailing the pandemic. The numerous and varying requirements for prior authorization requests often result in substantial adverse effects on the health care system, physicians, and most importantly patient outcomes and well-being.

8. **Provide support for Resident Physicians and Students**

Many residents and medical students are playing a critical role in responding to the COVID-19 crisis and providing care to patients on the frontlines. For residents, COVID-19 is inflicting additional strain as they are redeployed from their primary training programs and put their health on the line caring for the sickest patients, many without appropriate personal protective equipment. Some medical schools, such as New York University, are graduating their students early to deploy them to care for patients during this public health crisis. Residents and early graduated medical students have an average debt of over $200,000, yet will not necessarily be supported by other programs to that provide direct financial support to hospitals and other physicians.

a. **We urge Congress to provide at least $20,000 of federal student loan forgiveness or $20,000 of tuition relief.** These benefits should also be made available to third- and fourth-year medical students who are willing, and deemed competent, to begin providing early direct patient care for patients with COVID-19, or who are making other significant contributions to the pandemic response through research, public health, and telemedicine.

b. **We also ask for flexibility in CMS's Graduate Medical Education (GME) reimbursement to hospitals to accommodate variations in training due to the COVID-19 response.** This flexibility should lengthen the initial residency period (IRP) for residents to allow them to extend their training, if necessary, to meet program and board certification requirements. CMS should also expand the cap at institutions where residents must extend their training to support an increased number of residents as new trainees begin while existing trainees remain to complete their programs.

9. **Mandate that HHS create a special enrollment period (SEP) for Affordable Care Act (ACA) marketplace plans.**

We appreciate the administrations and Congress' efforts to expand access to COVID-19 testing without cost sharing. However, millions remain uninsured or underinsured. ACP is concerned that those without comprehensive coverage may be less likely to seek and receive testing and treatment of COVID-19, endangering themselves and others. So far, 12 states (including the District of Columbia) with state-based exchanges have opened up a SEP. We urge Congress to mandate that HHS follow suit and open temporary SEPs for federally-facilitated exchanges to provide another opportunity for people to enroll in comprehensive insurance that will cover COVID-19 testing, treatment, and other crucial services.

10. Ensure sufficient funding, distribution based on health need, and end to price-gouging and bidding for PPEs.

We are pleased with President Trump's recent decision to invoke the Defense Production Act (DPA) to require 3M to manufacture PPE but also urge Congress to act to rapidly increase the supply of PPE for physicians, nurses, and other frontline health care workers and ensure equitable distribution of supplies based on public health need at a fair price. In the current environment, states and hospitals are competing against each other for limited supplies of PPE, driving up prices and placing a strain on budgets.[1] With tens of thousands of lives at risk, these critical supplies must be distributed based on public health best practices and the need on the ground, not through bidding wars.

11. Reauthorize the Conrad State 30 J-1 visa waiver program through the Conrad State 30 and Physician Access Reauthorization Act (S. 948).

The College has long recognized the value of international medical graduates (IMGs) and their contributions to health care delivery in this country. Many IMGs provide care in medically underserved areas by participating in J-1 visa waiver programs, including Conrad 30. We support the reauthorization of this program without delay, and also believe that it should be made permanent to give physicians with J-1 visas certainty that they may continue to practice in underserved areas since a vastly larger number of IMGs are currently serving on the front lines of U.S. healthcare, both under J-1 and H1B training visas and in other forms. This legislation also includes a provision that would address the current backlog in the system for physicians on J-1 visas who wish to acquire a green card to move to a more permanent residency status.

During this pandemic the role of IMGs is even more critical to care for the thousands of patients battling COVID-19. ACP urges the passage of S. 948 and also recommends that medical residents and physicians on J-1 and H-1B visas be redeployed as needed to respond to the COVID-19 pandemic. We also support the temporary extension of visas and other protected status for medical residents and physicians so that they can continue to treat patients in this country during the COVID-19 pandemic.

12. Ensure sufficient availability of prescription drugs, including addressing growing shortages and price-gouging.

We urge Congress to act in the next COVID-19 stimulus bill to address the negative impact drug shortages have on the health of the public and urge federal government action over the reported shortages of several drugs that have been exacerbated by the COVID-19 pandemic. The College strongly believes that to address current and looming shortages, the federal government should work with pharmaceutical companies to

[1] Romm, Tony, Jeanne Whalen, Aaron Gregg, and Tom Hamburger. "Scramble for Medical Equipment Descends into Chaos as U.S. States and Hospitals Compete for Rare Supplies." The Washington Post, March 25, 2020. https://www.washingtonpost.com/business/2020/03/24/scramble-medical-equipment-descends-into-chaos-us-states-hospitals-compete-rare-supplies/.

ensure there is an adequate supply of pharmaceutical therapies and vaccines to protect and treat the U.S. population. Specifically, if necessary to mitigate an existing shortage and protect the general welfare of the public, ACP supports the government invoking federal law to allow generic drug makers to bypass a drug manufacturer's patent to produce a drug for the government.

13. Ensure expanded liability protections for physicians

While current law in some states may provide sufficient liability protections for crisis and emergency care, physicians need assurance and protection from liability for taking on new responsibilities, roles, and changes in how care is delivered due to COVID-19. These include:

- suspension of most elective in-person visits and replace them with virtual visits to the extent possible as requested by the Centers for Disease Control and Prevention (CDC) and other public health authorities;
- providing treatments or care outside their general practice areas and for which they may not have the most up-to-date knowledge;
- coming out of retirement to alleviate workforce shortages related to the growing health crisis caused by the COVID-19 pandemic;
- inadequate supplies of safety equipment that could result in the transmission of the virus from patient to physician and then to additional patients, or directly from one patient to another;
- shortages of equipment, such as ventilators, that can force facilities and physicians to ration care;
- inadequate testing that could lead to delayed or inaccurate diagnosis; and
- delays in treatment for patients with conditions other than coronavirus.

In these and other scenarios, physicians and other clinicians face the threat of medical liability lawsuits due to circumstances that are beyond their control. These lawsuits may come months or even years after the current ordeal when the public memory of their sacrifices may be forgotten.

Congress has already acknowledged that liability is a significant impediment to physicians and other clinicians. In section 3215 of the recently enacted CARES Act, Congress included important liability protections for health care volunteers who respond to the COVID-19 crisis. Also, Congress has passed laws that provide various liability protections for physicians and other clinicians who volunteer or who provide health care services under certain, limited circumstances, including: the Public Readiness and Emergency Preparedness Act (PREP Act); the Volunteer Protection Act of 1997; and section 194 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). There are various state liability protections available as well.

While ACP supports Congress considering broader liability protections for physicians and other clinicians and the facilities in which they practice as they continue their efforts to

treat COVID-19 under unprecedented conditions, such protections should not apply to gross negligence or intentional harm to patients.

14. **Congress should act to prohibit triage guidelines in any crisis standards of care plans in federal programs, or in facilities receiving federal funding, that are discriminatory against classes or categories of patients based on age, race, ethnicity, disability, sex, gender identity, social status or other personal characteristics.**

ACP's Board of Regents recently adopted a policy statement reaffirming our commitment to non-discrimination against categories of patients based on personal characteristics, https://www.acponline.org/acp_policy/policies/acp_policy_on_non-discrimination_in_the_stewardship_of_healthcare_resources_in_health_system_catastrophes_including_covid-19_2020.pdf.

We observe in this policy that:

"Large-scale health catastrophes, including from infectious causes, can overwhelm health care systems, stressing the norms of health care delivery and the patient–physician relationship. Triage is often needed; stewardship and allocation of resources becomes even more necessary in overwhelmingly high demand circumstances. While the physician's responsibility remain with the health and welfare of individual patients under the physician's care, the well-being of the community as a whole must also be considered at a systems level including in institutional policies and other guidelines. This requires prioritization of resources. But prioritization must not be discrimination. Fairness and other professional responsibilities of physicians require that clinicians, their institutions and health care systems not discriminate against a class or category of patients (e.g., based on age, race, ethnicity, disability, sex, gender identity, social status or other personal characteristics). Treatment decisions must not be based on unjust and prejudicial criteria." Instead, ". . . resource allocation decisions should be made based on patient need, prognosis (determined by objective scientific measures and informed clinical judgment) and effectiveness (i.e., the likelihood that the therapy will help the patient recover). Allocation of treatments must maximize the number of patients who will recover" and not, for example, "life-years" (long-term life expectancy), an approach that is, "inherently biased against the elderly and the disabled."

We are concerned about reports that states and health care facilities that receive federal funding are adopting crisis standards of care plans that are discriminatory and are in conflict with ACP policy and the ethical obligations of physicians. Many persons with disabilities, as well as advocates for older persons, are similarly concerned that patients will be discriminated against in crisis standards of care triage guidelines. We urge Congress to take action to prohibit discriminatory standards of care by any state or facility receiving federal funding.

15. **Ensure sufficient funding for public health data surveillance and analytics infrastructure modernization. Additionally, ensure efforts to implement improvements to public health data surveillance and analytics are implemented consistently across vendors and states, and incorporate appropriate and transparent privacy guardrails.**

    Improving the public health surveillance and analytics infrastructure is important in addressing the next phase of the current COVID-19 pandemic, as well as improving the ability of public health departments to address future public health emergencies. ACP has concerns that physicians' existing health information technology (IT) systems lack the ability to seamlessly report COVID-19 cases and public health departments vary in their ability to accept these reports. The goal for improving these processes should focus on automating data sharing from health IT systems with minimal additional effort required by clinicians, and implementing these programs through a coordinated effort focused on agreed upon standards that are implemented consistently across vendors and states. Further, Congress should take into account and incorporate necessary privacy guardrails as these surveillance and analytics systems are improved and expanded.

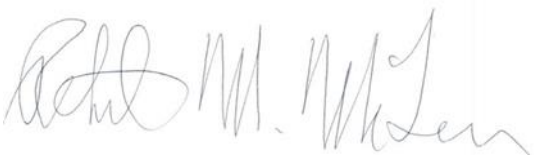
16. **Ensure adequate funding and oversight to support the broadband infrastructure needed to support telehealth activities.**

    Given the rapid expansion and deployment of telehealth services to address the COVID-19 pandemic, a strong broadband infrastructure is needed to provide high-speed, reliable connections for telehealth. Continued investment, with appropriate oversight of funding allocations, is important to support a strong network for clinicians offering telehealth during the current pandemic and moving forward.

Conclusion

We offer these recommendations in the spirit of improving the next COVID-19 response bill so that it provides the support needed to both physicians and patients, and urge that they be included in any final legislation. We urge Congress to work in a bipartisan manner to ensure that these policies are enacted without further delay to meet the health care and economic challenges that we face during this crisis.

Sincerely



Robert M. McLean, MD, MACP
President