April 15, 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 am writing to share our appreciation of the major steps that the Centers for Medicare & Medicaid Services (CMS) has taken to address this unprecedented public health emergency (PHE) caused by the COVID-19 pandemic, including numerous policy and regulatory changes to help support and sustain physicians and their practices, and to suggest additional action to help frontline physicians and their care teams maintain their practices, increase health system capacity, and expand access to affordable testing and treatment.

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.

ACP recommends additional emergency actions that CMS should take as soon as possible. We believe these actions 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.

Medicare Accelerated and Advance Payment Program

We are appreciative of the Agency's efforts to expand and simplify enrollment in the Medicare Accelerated and Advance Payment Program. ACP further appreciates the speed at which CMS has been working to deliver advanced payments to physicians on the frontlines of the COVID-19 pandemic. These payments are essential to ensuring that our nation's healthcare workforce has the resources it needs to combat this pandemic. **We urge CMS to continue to work towards further decreasing processing time for applications and to extend the amount**

of time by which physicians would have to pay back Medicare for advance payments. Specifically, the College strongly recommends that this loan payment timeframe be extended to at least a year from the date that the load payment is received. Given the economic uncertainty surrounding this pandemic, extending the payback timeline would give physicians additional flexibility to weather an ever-changing economic forecast.

Pay Parity for Telephone E/M Claims and Expanding Telehealth and Telephone Payments

While we understand that CPT codes 99201-99215 are available via telehealth at rates comparable to in-person visits, we are concerned that many patients are unable to connect via telehealth with their physicians, as they do not have compatible devices. We have heard from our physicians that during this crisis, they have been able to conduct successful audio-only telephone visits with patients, in lieu of in-person or telehealth visits, obtaining about 90 percent of the information they would collect using audio and video capable equipment. **Accordingly, we strongly encourage CMS to provide parity between office visit codes (99201-99215) and telephone E/M codes (99441-99443) to ensure that patients have maximum ability to engage with their doctors during this public health emergency, and to consider making this a permanent change thereafter. This could be done by correlating RVUs from CPT codes 99212-99214 to 99441-99443.**

Additionally, CMS should make it clear that covered telehealth and telephone visits include the Medicare annual wellness visit (G0438 and G0439) and ensure that the Medicare Administrative Contractors (MACs) are issuing appropriate payment for those services. The information included in the interim rule dated March 30 contains guidance that appears to be conflicting with regard to these important visits. These visits 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. This allows the physician to detect at an early stage any concerning symptoms that may be addressed before escalating into a more serious condition.

Prior Authorization

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. There are clear 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.[i] 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 continues to recommend that CMS work through all appropriate channels to temporarily waive all prior authorization requirements during this period of national emergency.**

Direct Supervision Requirements

The College welcomes the recent decision by the Agency to allow attending physicians and residents/fellows the ability to communicate over interactive systems by waiving the in-person supervision requirement. This is an important step that promotes efficient patient care as they allow physicians and supervisees to work together unencumbered by social distancing restrictions. While we are encouraged by these changes, the College urges CMS to consider additional changes to supervision requirements that would further promote patient care. **ACP encourages CMS to temporarily allow residents and fellows to see patients and bill for the care they are providing independently of the attending physician as under the primary care exception rule without requiring asynchronous audio and video equipment.** These measures would continue to allow the attending physician and residents/fellows to discuss cases at the end of the day to ensure that proper care and guidelines are strenuously followed. Residents and fellows are highly trained in medicine and have the skills to care for critical patients during emergency situations in which the healthcare workforce is severely strained. We recognize that these measures are unprecedented, but we must take unprecedented actions necessary to ensure that we are able to soundly and swiftly defeat this virus.

Merit-Based Incentive Payment System (MIPS)

ACP urges CMS to extend the Merit-Based Incentive Payment System (MIPS) reporting deadline for 2019 data until the end of 2020. ACP appreciates CMS extending the deadline to April 30, but it does not go far enough. COVID-19 will still be at the height of its risk curve by the end of April. As past performance data indicates, clinicians tend to score high and bonuses are competitive. Asking clinicians to submit all 2019 data by April 30 will ask many to forgo any realistic chance of earning a positive reimbursement. Extending the deadline to collect more data is critical to the program's future. The program relies on data from past performance years to set benchmarks for individual measures and collective scoring thresholds. Without robust 2019 data, the accuracy and validity of future benchmarks will suffer. Preserving 2019 data is even more critical given the unreliability of 2020 data.

CMS should replace the extreme and uncontrollable circumstances exception application with an automatic exception in which all clinicians are automatically held harmless from MIPS penalties for the 2019 performance year, including those who submit data for two or more performance categories and those evaluated under the APM scoring standard. We appreciate 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, this

approach adds unnecessary administrative burden at a time physician practices cannot afford it. It will also adversely impact clinicians who are scored under the MIPS APM scoring standard. Because data is evaluated and scored at the APM Entity level, if even a single clinician or TIN sends a sufficient amount of data and fails to submit a hardship exception, it would trigger a MIPS score and payment adjustment for the entire ACO or APM Entity.

CMS should also extend the deadline for reporting 2019 performance data to all Advanced APM participants and hold them harmless from any negative performance adjustments due to lack of 2019 data. ACP appreciates the accommodations CMS has made for MIPS reporters, whicih underscores the importance of extending similar considerations and protections to Advanced APM participants.

ACP calls on CMS to hold clinicians harmless from all MIPS penalties or losses owed under risk-bearing APMs for the 2020 performance year. ACP appreciates the magnitude of this request, but such action is needed to ensure the future viability of the value-based movement with such an unprecedented crisis. ACP appreciates CMS excluding the first six months of claims data from 2020 performance for quality reporting and value-based purchasing programs. However, we are now more than three months into the year with no clear end to the pandemic in sight. This disaster will have broad-ranging impacts on performance measures, patient attribution, risk adjustment, target pricing, and financial benchmarks for months, if not years, after the public health emergency phase has technically concluded.

There is no equivalent protection for clinicians participating in Advanced APMs. ACP commends CMS for capping certain episode payments at the target price for the Comprehensive Care for Joint Replacement Model, but there need to be widespread protections for clinicians participating in all types of Advanced APMs. While ACP understands the Agency will need time to determine the best approach to adjusting future target pricing, financial benchmarks, and performance thresholds without 2020 data, clinicians need assurances soon. According to a recent National Association of ACOs survey, over half of risk-bearing Medicare Shared Savings Program ACOs are considering dropping out of the program by May 31, the deadline by which they must decide whether to drop out of the MSSP without owing losses for 2020 performance. If CMS does not act fast, we stand to lose much of the progress gained under the value-based payment reform movement, particularly risk-bearing APMs.

ACP urges CMS to extend all APM application related deadlines in 2020. The Primary Care First and Direct Contracting Models are both actively soliciting participants for the first round of participation and have upcoming participation agreement deadlines. Practices are in the midst of battling the COVID-19 crisis and do not have the bandwidth to perform the sophisticated cost-benefit calculations and make major decisions such as participating in a brand-new APM. If CMS wants any chance of successfully soliciting a robust introductory class of participants for these models, it must delay the impending participation agreement deadlines. At the same time, ACP reiterates the importance of providing practices with sufficient advance notice about model details and practice-specific data and enough time to make the necessary calculations and decisions.

ACP urges CMS to defer required advancement to higher risk tracks within the MSSP for 2021 and to provide up front funding sources for practices to join Advanced APMs, particularly small, rural, and independent practices. Practices are struggling to financially tread water, and financial reserves in the wake of dealing with the COVID-19 crisis will be completely depleted. They will not be in the same place to advance to higher risk or join new risk-bearing APMs. If CMS does not make appropriate adjustments to support practices and allow them to rebuild during this vulnerable time, participation in APMs will at best freeze in place, and more likely, decline. Clinicians can be expected to pay back advance payments over a period of time, so this would ultimately cost CMS nothing but will be critical in continuing to advance participation in APMs.

Medicaid Pay Parity

ACP urges CMS to work with states toward the goal of ensuring Medicaid pay parity for all physicians, especially 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 while we support pay parity for all specialties, at a minimum, pay parity should be restored for primary care specialties and related subspecialties. This will ensure that primary care physicians 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.

Increased Medicare Rates for Uninsured to 110%

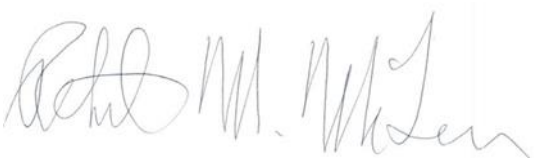
ACP urges CMS to reimburse physicians and hospitals at 110 percent of Medicare rates for care provided to uninsured patients. With tens of millions of Americans at risk of losing their jobs and employer-based coverage, many may end up uninsured, leaving them unable to afford their care including for COVID-19-related complications. Such uncompensated care will further threaten the viability of physician practices. Reimbursing physicians and hospitals at 110 percent of Medicare rates for COVID-19-related expenses for uninsured patients will help to make care more affordable and accessible for uninsured patients, prevent the further spread of COVID-19, and enable many practices and hospitals to keep their doors open, particularly those in rural and underserved areas.

In Conclusion

ACP is appreciative and encouraged by the actions taken by CMS to date that will be enormously beneficial to physicians and their teams in both caring for patients impacted by this pandemic and for patients at-large. At the same time, we continue to strongly recommend that CMS take additional emergency actions to assist physicians and other clinicians with the resources and burden reduction they need to be successful in treating this pandemic. ACP would like to offer our full assistance toward these efforts, and we intend to continue voicing

the perspective of internal medicine physicians, who are witnessing firsthand the impact of this pandemic. Please contact Brian Outland, PhD, Director, Regulatory Affairs, by phone at 202-261-4544 or email at boutland@acponline.org if you have questions or need additional information.

Sincerely,



Robert M. McLean, MD, MACP
President

[i] 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