



March 20, 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 urge the Centers for Medicare and Medicaid Services (CMS) to enact additional regulatory relief to address the national threat of the Coronavirus Disease 2019 (COVID-19). While we are appreciative of the many policies announced by CMS to support physicians and their care teams during this national emergency, ACP has specific regulatory recommendations, as detailed below, that we strongly believe are necessary to further relieve the burden on physicians during this crisis. Physicians on the front lines of the COVID-19 crisis need unprecedented and swift action in order to be able to care for their patients with the SARS-CoV-2 virus, as well as attend to the needs of their broader patient population. This is particularly true of internal medicine specialists and subspecialists, the specialty that takes care of millions of patients who are most at risk of acquiring COVID-19, including the elderly and those with chronic pre-existing conditions such as heart disease, diabetes, and asthma.

The American College of Physicians is the largest medical specialty organization and the second-largest physician group 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.

The College sincerely appreciates the recent actions by CMS to provide regulatory flexibilities that help healthcare clinicians participating in both Medicare and Medicaid respond to and contain the spread of COVID-19, while also caring for the needs of their broader patient population during this time of crisis. ACP is particularly appreciative of CMS' March 17 announcement on policy changes that will significantly expand patient access to telehealth services, ease HIPAA rules, and allow physicians to waive deductibles for such services. However, ACP believes that additional steps can and should be taken immediately to help patients receive the care they need in the most efficient, timely, and safe manner possible. CMS

also should suspend a number of regulatory and reporting requirements during the duration of the national emergency.

Per the College's [March 18, 2020 letter to CMS](#) regarding coverage of and payment for telehealth and other remotely-provided services, ACP continues to strongly recommend that the Agency:

- **Provide reimbursement for CPT codes 99441 – 99443, which are telephone evaluation and management services** provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.
- **Allow physicians to waive co-pays for all types of telemedicine services.** In the guidance released this week, the Agency provided this flexibility for telehealth video visits; however, this authority was not granted to physicians for virtual check-ins or e-visits. This approach can be confusing and burdensome for both patients and practices, who will then have to ensure they differentiate between which services do require a co-pay and which do not, and also disadvantages those that do not have access to appropriate telehealth technology.
- **Make all types of telemedicine, including telehealth visits, virtual check-ins, phone consultations, and e-visits, available to both new and established patients.** While ACP recognizes the inherent challenges in this approach over the longer term, with clinicians having to provide non-face-to-face services and advice to patients for whom they have not yet provided a physician exam, the priority at this time is providing access to patients when and how they need it, particularly those who are more vulnerable to the effects of potential exposure to COVID-19.
- **Work with state and Medicaid programs to fully engage the full spectrum of remote telehealth video and telephone services.** Nearly all Medicaid programs cover telemedicine delivered via live video, but fewer states cover remote patient monitoring or audio-only phone consults, which may be especially necessary in areas with limited broadband capacity. States should be encouraged to implement telehealth triage so that emergency departments aren't overburdened with non-emergency cases.
  - Further, since some states [reimburse telehealth services at lower rates than in-person services](#), states should be strongly encouraged to provide reimbursement parity for COVID-19-related care. We also urge CMS to expedite state plan amendments and waivers necessary to facilitate telehealth and address COVID-19.

There is more that can and should be done immediately to ensure that patients are able to get the care they need in the most efficient, timely, and safe manner.

## Evaluation and Management Coding Changes for 2021

**The College urges CMS to ensure that the Evaluation and Management (E/M) coding changes, as finalized in the 2020 Physician Fee Schedule final rule, are implemented on January 1, 2021 without delay or other changes that will undermine their impact,** to ensure stability and more appropriate payment for internal medicine specialists and other physicians that provide primary and comprehensive care—critically important during this time of extreme instability in the health care system. These changes include:

- Higher physician work relative value units (RVUs) for new and established office visit codes, leading to increased payments for them. The higher work RVUs are essential and based on evidence that shows that current payment levels undervalue the complexity of physician work in providing primary and cognitive care to patients.
- Reduced documentation requirements for office visit codes, which enables physicians to select and document for each visit based on medical decision-making or total time. These changes will allow physicians to spend more time with patients and less on documentation and paperwork.
- Expanded and improved payment for care management services. Appropriate payment for care management will make it possible for physicians to coordinate care with others on the patient’s clinical care team, leading to better health outcomes.
- The new visit complexity code that recognizes the additional resource costs inherent to furnishing certain types of office visits.

Such complex Evaluation and Management services, long undervalued, are precisely the types of skills that internal medicine physicians, and other primary and comprehensive care physicians, are bringing to the testing, diagnosis, and treatment of COVID-19. Yet as physicians move to virtual visits whenever possible, instead of in-person E/M codes, their practices will experience a substantial loss of revenue. The certainty that the planned E/M increases and the visit complexity code will be implemented without delay or other changes that will undermine them, even though many are still more than 9 months away, is essential to the continued viability of their practices.

## Prior Authorization

**ACP recommends CMS waive all prior authorization (PA) requirements during this period of national emergency.** As ACP has long noted, the PA process is extremely burdensome due to the varying requirements and procedures for collecting the data needed to complete the authorization request among both private and public payers, regardless of the current COVID-19 national emergency. Physicians report frequent care delays as a direct result of PA as well as negative impacts on clinical outcomes. There are clear cost effects on physician practices as well—with the average burden on primary care physicians ranging from \$2161 to \$3430 per FTE

physician annually for these activities.<sup>1</sup> Most recently, ACP has heard from our frontline physician members regarding care delays due to PA occurring during this national public health emergency. Specifically, members have raised concerns regarding patients in hospitals awaiting PA approval for discharge (i.e., discharges into Skilled Nursing Facilities have been a common complaint). These delays are ranging from four days to two weeks, thus resulting in patients occupying hospital beds that could be used during this emergency.

### **Quality Payment Program**

Clinicians need to be able to focus their energy and resources on treating patients and curtailing this pandemic with all the resources at their disposal, rather than having to meet regulatory deadlines or fear the impact of regulatory programs on their bottom lines for reasons outside of their control. To that end, **ACP urges CMS to extend the upcoming March 31 Merit-Based Incentive Payment System (MIPS) reporting deadline for 2019 data to the end of 2020.** This will allow practices to focus on treating their patients during the SARS-CoV-2 virus crisis. This is particularly important for internal medicine specialists as many of the patients most at risk from the COVID-19 are or will be treated by them, especially older patients and those with pre-existing conditions like heart disease, asthma, and diabetes.

**The College also recommends holding all physicians and other clinicians in both MIPS and advanced Alternative Payment Models (APMs) harmless from performance-related penalties for the 2020 performance year.** The Agency must ensure clinicians are not inappropriately penalized for the extreme costs of providing care during this crisis—and likely for months afterward. The full effects of this devastating pandemic may be difficult if not impossible to isolate. For example, ACP has heard from many of its members in large and small practices alike that the economic viability of their practices is already at extreme risk because of increased expenses associated with COVID-19 and reduced revenue from cancellation of in-office visits. The increased flexibility provided by the Administration with regard to telehealth is helpful, but many practices are still challenged to obtain the necessary software—particularly if they want to conduct the types of telehealth visits that allow for the appropriate amount of time for patient assessment and that are reimbursed equivalently to in-person visits—and to implement significantly revised workflows. With so many practices simply trying to keep their doors open, layering in performance-related penalties would be extremely damaging to the health care system overall. Additionally, allowing these penalties to go into place could also serve to derail the progress of the value-based payment movement, which is important over the longer term.

---

<sup>1</sup> 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>

Additional recommendations to the Quality Payment Program:

- **Extend the MIPS measure submission deadline for measure developers for the 2021 performance year.** In addition, CMS should consider allowing QCDR measure developers to submit a list of preliminary measures for CMS to include in proposed rulemaking as they concurrently work on completing testing and final specification changes. These flexibilities will be especially important as CMS looks for stakeholders to develop more specialty-specific measures in preparation for the MIPS Value Pathway (MVP).
- **Commit to a graduated implementation timeline for the MVP,** now even more critical in the wake of the COVID-19 crisis.
- **Extend 2021 application cycle deadlines and provide additional application opportunities for Advanced APMs.** 2021 application and participation agreement deadlines should be delayed and extended for the MSSP, Primary Care First, Direct Contracting, and other APMs. CMS should also consider committing to an additional application cycle for the Direct Contracting model for the 2022 performance year and opening up the Primary Care First 2022 application cycle to non-CPC+ clinicians.
- **CMS should consider additional options to support APM participants, including up front funding opportunities and reinsurance options.** Financial resources will be depleted in the wake of COVID-19, making it more challenging to overcome entry barriers to APMs than ever before. Additional support at this time would go a long way to helping clinicians continue to transition to APMs, particularly risk-bearing APMs, which are a priority for the Administration.
- **Make appropriate adjustments to ensure clinicians in value-based programs and models do not have their cost and quality performance negatively impacted by helping patients in the wake of the COVID-19 crisis.** As with any pandemic, COVID-19 has resulted in a widespread spike in testing, complications, and hospitalizations, which will significantly impact quality and cost metrics, financial benchmarks and target pricing, risk adjustment, and patient attribution. For clinicians engaged in value-based reimbursement models, this new normal makes it impossible to effectively compare performance to past and future benchmarks. Beyond more obvious implications such as increased spending on testing, or for treating complications for COVID-19 positive patients, there are a host of other downstream impacts. For example, because of the necessary shift by practices to take care of more urgent or emergent issues rather than routine or preventive services, attribution for population-based models will be skewed to only the sickest patients. Hospital admissions will no longer be an accurate indicator for quality performance, particularly for patients suffering from multiple co-morbidities, who are particularly vulnerable to COVID-19. Beyond the short-term impact on 2020 savings calculations, there is also the long-term impact on performance measures and global financial benchmarks to consider, as these will be used to gauge future

performance. For these reasons, CMS may consider completely eliminating claims data from calendar months significantly impacted by the virus from performance and benchmark calculations.

### **Health Information Technology - 21st Century Cures Act Implementation:**

*ONC's Interoperability, Information Blocking, and the ONC Health IT Certification Program ("Information Blocking") and CMS' Interoperability and Patient Access ("Patient Access") Final Regulations:*

**ACP recommends both ONC and CMS offer blanket hardship exceptions for clinicians regarding all regulatory compliance deadlines within the "Information Blocking" and "Patient Access" final regulations for the duration of this national emergency.** We support ONC's and CMS' efforts to move these important regulations forward, and understand the importance and need for enhanced health information exchange and patient access to health data in national emergencies; however, the existing health IT systems are not where they need to be in order to address those needs immediately, and as mentioned numerous times throughout this letter, all resources and efforts should be focused on curtailing the COVID-19 pandemic. The need to ensure greater access to medical services for patients while limiting the risk of infection is critical, and ACP greatly appreciates CMS' recent efforts to expand the use of telehealth services to help address the COVID-19 pandemic. With the influx of patients seeking care virtually, as well as the urgent need to update workflows and other health IT system adjustments, frontline clinicians need to focus on using their health IT systems to address the emergent COVID-19 national emergency. ACP is concerned that the technical compliance deadlines, as well as the financial implications of health IT upgrades, contained within the recent ONC "Information Blocking" and CMS "Patient Access" final regulations will divert time and resources away from the existing national public health emergency.

### **Medicare Advantage and Medicare Part D (prescription drug coverage)**

Medicare Advantage and Medicare Part D are important components of the Medicare program. During the current rulemaking cycle, CMS has proposed changes to these programs, on which ACP is planning to review and submit comments. During the national COVID-19 emergency, it is crucial that our physicians and their teams be allowed to focus on patient care. **We urge CMS to extend the comment period on the proposed rules for these programs until at least October 5, 2020, in order to allow physicians to focus on delivering critical care during this public health emergency.** Our healthcare system needs all hands on deck, and this action would go a long way to help achieve the ongoing efforts to isolate and treat COVID-19.

## Appropriate Use Criteria (AUC)

CMS [informed](#) Medicare Administrative Contractors (MACs) in July 2019 that effective January 1, 2020, MACs should accept the Appropriate Use Criteria (AUC) related HCPCS modifiers on claims. CMS noted that it intended to move forward with the program in 2020 and will fully implement the program in 2021. ACP has continuously urged CMS to pursue quality-related reforms of the Medicare program in a manner that is not disruptive or burdensome for physicians and their patients. Our comments to the agency in [2016](#), [2017](#), [2018](#), and [2019](#), along with our additional [advocacy](#) efforts, have urged CMS to minimize administrative burden, provide maximum transparency, and ultimately roll-out the program in a manner that is not disruptive to physicians and their patients. To date, no statutory changes have been made and CMS notified Medicare contractors on July 26, 2019 that they should begin accepting the AUC-related code modifiers on claim forms beginning January 1, 2020. Given the declaration that a Public Health Emergency exists due to COVID-19 by Secretary Azar and the regulatory relief measures taken by you, we urge CMS to recognize that existing AUC policies and procedures are in conflict with the ability of physicians to focus their time and resources on providing patient care to combat COVID-19. **Therefore, we ask that CMS work together with Congress to suspend AUC requirements until such time that CMS can confirm that these requirements no longer place an extraordinary burden on physicians in meeting the current and expected demands on their services.** The College stands ready to work with CMS on these modifications.

We commend you and the Administration for the numerous actions you have already taken to provide more options and flexibility for physicians to provide care via telemedicine, as well as additional regulatory relief with regard to “provider” enrollment requirements, blanket waivers under Section 1135 of the Social Security Act, and relaxing of rules around claims appeals. There is still much more that can and should be done. We sincerely appreciate your urgent consideration of our recommendations to take these additional necessary steps. Please contact Brian Outland, PhD, Director, Regulatory Affairs, by phone at 202-261-4544 or email at [boutland@acponline.org](mailto:boutland@acponline.org) if you have questions or need additional information.

Sincerely,

A handwritten signature in black ink, appearing to read "Robert M. McLean". The signature is fluid and cursive, with the first name being the most prominent.

Robert M. McLean, MD, FACP  
President