American College of Physicians
Leading Internal Medicine, Improving Lives

March 30, 2020

Matt Salo
Executive Director
National Association of Medicaid Directors
601 New Jersey Avenue, NW
Washington, D.C. 20001

Dear Mr. Salo:

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 write to express the College's sincere appreciation for the work the National Association of Medicaid Directors (NAMD) is doing to keep its members informed of the new flexibilities offered to state Medicaid programs to address the urgent and increasingly dire situation regarding COVID-19. Should states take advantage of these policies, these changes will greatly assist physicians and other clinicians on the front lines of this pandemic. ACP members include 159,000 internal medicine physicians (internists), related subspecialists, 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.

The College recognizes NAMD's unique and important role in providing resources and guidance while representing state Medicaid directors as they execute their responsibilities under the Medicaid program across the country. ACP is very appreciative of the efforts thus far by state Medicaid programs in response to the national emergency and the Public Health Emergency (PHE) declared by the Administration. Some highlights include actions by your members to waive cost-sharing for visits and testing, waive prior authorization requirements, and allow early prescription refills. ACP is encouraged by these announcements that will hopefully allow physicians and other clinicians to focus on providing patient care during this pandemic.

While the College applauds these actions, we simultaneously urge NAMD to encourage their members to take additional steps to ensure the safety of patients and internal medicine specialists and other physicians on the front lines of care. While actions taken to date will have a positive impact on the trajectory of COVID-19, ACP believes there are further steps that will assist physicians in meeting these unprecedented challenges and patient needs without derailing the important progress that is being made to improve the quality and efficiency of care. In direct response to the efforts by NAMD and their members, ACP would like to make the following comments and recommendations:

Telehealth

ACP appreciates the steps undertaken by state Medicaid programs to address the need for telehealth solutions during this pandemic. These efforts strengthen telehealth offerings, encourage social distancing, and allow patients to receive care from the safety of their own homes. However, the College believes that there are additional policy changes states can make that will enable patients to receive the care they need without exposing themselves to the risk of COVID-19. The Medicaid and

CHIP Payment and Access Commission (MACPAC) published an excellent roadmap that highlights existing Medicaid policies, federal guidelines, as well as considerations for the adoption of telehealth. In light of recent Centers for Medicare and Medicaid Services (CMS) guidance and in an effort to encourage uniformity among payers in their telehealth offerings, ACP recommends that state Medicaid Fee-for-Service programs and Medicaid Managed Care Organizations (MCOs) consider taking the following actions:

- **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. **Additionally, we urge Medicaid programs to pay for these services at the same rate as in-person visits during this national emergency.** Not reimbursing for telephone visits (99441-99443) at a payment level on par with in-person visits disproportionately affects physicians and practices caring for elderly and vulnerable patients, many of whom are managing multiple chronic conditions, do not have smartphones, or may have one but do not know how to use FaceTime or Skype. These individuals are the ones 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 still receiving uninterrupted primary care services.
- **To the extent that Medicaid programs have co-pays, allow physicians to waive co-pays for all types of telemedicine services.** While Medicare and some private carriers have announced policy changes to waive cost-sharing for these visits, we urge all insurance programs (public and private) to consider temporarily allowing physicians to waive cost-sharing for all types of telehealth and telemedicine visits. This will encourage patients to seek the care they need from the safety of their homes so that they are not exposing themselves or others to the risk of infection.
- **Make all types of telemedicine, including telehealth visits, virtual check-ins, phone consultations, and e-visits, available to both new and established patients**. CMS issued guidance that allows physicians to bill for telehealth visits associated with established patients, but notes that the agency will not audit claims to discern as to whether a relationship existed prior to the visit. ACP has encouraged CMS to reimburse for both new and established patient visits. To the extent that state Medicaid programs have not already made these changes, the College urges NAMD to consider asking their members to also make these visits available to both new and established patients.

"Provider" Enrollment/Credentialing

The College appreciates actions by NAMD's members to reduce physician burden during this challenging time. Some insurers have modified existing credentialing processes and are offering provisional credentialing. As you may know, CMS has also taken emergency actions to address COVID-19 by modifying certain enrollment requirements. ACP supports these actions and welcomes additional action by all public and private insurers to ease the credentialing process during this national emergency. For example, Medicaid directors may consider:

- Temporarily waiving any fees associated with the enrollment process;
- Establishing toll-free hotlines to enroll and receive temporary billing privileges; and

- Temporarily postponing all revalidation efforts.

Evaluation and Management Coding Changes for 2021

As you may also know, CMS finalized Evaluation and Management (E/M) coding changes in the 2020 Medicare Physician Fee Schedule (MPFS) final rule. These changes are currently scheduled to be implemented in the Medicare program on January 1, 2021. 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, show 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.
- A new visit complexity code that recognizes the additional resource costs inherent to furnishing certain types of office visits.

These complex Evaluation and Management services, long undervalued, are precisely the types of skills that internal medicine specialists that provide primary and comprehensive care services are bringing to the testing, diagnosis, and treatment of COVID-19, as well as to their broader patient population. 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.

While these changes are being made in the Medicare program, it is important that physicians billing for E/M visits for patients with Medicaid have a uniform set of rules and guidelines to provide clarity and eliminate the potential for significant physician burden. **Therefore, ACP recommends that NAMD encourage their members to adopt the changes to documentation requirements, as well the Medicare values finalized by CMS, to ensure that all physicians are operating by one set of rules and standards so they are able to focus on patients.**

Prior Authorization during COVID-19 National Emergency

As the leading national association representing state Medicaid directors, your organization is aware of the administrative complexities associated with the health care industry; specifically, how all payers have their own approaches, rules, and requirements related to prior authorizations, among a number of other billing and reporting requirements discussed throughout this letter. These hurdles 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 effects on the health care system, physicians, and most importantly patient outcomes and well-being. Physicians continue to report frequent care delays as a direct result of prior authorizations, as well as negative impacts on clinical outcomes. There are clear cost effects on physician practices as well—with the annual average burden on primary care physicians ranging from $2,161 to $3,430 per full-time employee for these

activities.[1] While we appreciate the numerous ongoing public and private industry efforts to streamline and automate the prior authorization process more broadly, and we understand the stress on state budgets without utilization controls, more can be done during this national 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.

ACP has heard from our frontline physician members regarding care delays due to prior authorization occurring during this national public health emergency. Specifically, members have raised concerns regarding patients in hospitals awaiting prior authorization 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. We greatly appreciate the efforts underway by many state Medicaid programs to get ahead of this pandemic. Many states have taken advantage of the Section 1135 waiver opportunity to waive certain requirements during this public health emergency. **In turn, ACP recommends that states consider using this waiver opportunity to temporarily waive all prior authorization requirements during this period of national emergency.** Additionally, the Medicaid managed care regulations provide additional flexibility for MCOs to waive prior authorization requirements. Therefore, we also urge state MCOs to **temporarily waive all prior authorization requirements during this period of national emergency**.

Home Health

ACP urges state Medicaid agencies to relax the Home Health Care (HHC) regulations for home-bound patients. There is a growing challenge to get patients discharged from the hospital as quickly and safely as possible. In an effort to keep patients safe, clinicians need to avoid sending these elderly patients to the lab for follow up testing to ensure continued improvement. Ideally, these patients should stay in their homes and not put themselves at risk. We urge states to consider allowing HHC agencies to come to homes to draw needed blood work. Currently, if individuals do not meet the home-bound status, they don't qualify for HHC and the only option is for them to go to a lab which will put them at risk for exposure to COVID-19.

Value-Based Payment Models and Performance Programs

ACP commends NAMD's leadership and its commitment to shifting the tide toward the efficient delivery of high-value care through their myriad performance-based incentive programs and models, including Medicaid Patient-Centered Medical Homes and Medicaid ACOs. In general, ACP is a strong supporter of such programs and their goal to promote better care for patients. In the wake of the COVID-19 pandemic, it becomes increasingly important for NAMD to work with CMS and state Medicaid directors to offer state Medicaid programs and the clinicians who participate in these types of innovative payment arrangements certain assurances that they will not be adversely impacted in publicly reported ratings, coverage determinations, and performance-based payments as a result of the strain on resources and complications that are a direct result of being on the front lines battling COVID-19.

[1] 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

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 reporting deadlines or fear the impact of quality improvement initiatives on their bottom lines for reasons outside of their control. To that end, **ACP urges any reporting deadlines for 2019 quality and cost data to be extended to the end of 2020. This will allow practices to focus on treating their patients during the COVID-19 crisis.** This is particularly important for internal medicine specialists as they will treat the vast majority of COVID-19 patients, particularly older patients and those with pre-existing conditions.

The College also recommends holding all physicians and other clinicians in value-based payment programs and Alternative Payment Models (APMs) harmless from performance-related penalties for the 2020 performance year. Clinicians must not be inappropriately penalized for the extreme costs of providing care during this crisis—and the subsequent rebuilding, which will likely persist for months afterward. The full effects of this devastating pandemic will be difficult, if not impossible, to isolate. ACP has heard from members in both large and small practices alike that the economic viability of their practices are at extremely high risk as a result of increased expenses associated with COVID-19 and reduced revenue from the cancellation of regular in-office visits. Many practices face challenges implementing significantly revised workflows and obtaining increasingly in-demand software—particularly those that have the necessary functionalities for remote services to be reimbursed equivalently to in-person visits. 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 has taken many years to evolve and is critical to the long-term goal of delivering high-value care more efficiently.

In addition, ACP offers the following recommendations:

- **Extend 2021 application cycle deadlines for all performance-based programs, including Patient-Centered Medical Homes and Accountable Care Organizations.** Clinicians should be focusing all of their resources on fighting COVID-19. They are not in a position to make cost-benefit calculations, approve new models through leadership, and undergo all of the necessary infrastructure changes and investments to get an APM off the ground. If insurers do not delay deadlines to participate in value-based models and programs, future performance rates will suffer.
- **Consider additional options to support clinicians who are participating in innovative payment models, 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.
- **Make appropriate adjustments to ensure increased health complications and costs as a result of COVID-19 do not negatively impact performance-based payments.** 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, 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 treating complications for COVID-19 positive patients, there are a host of other

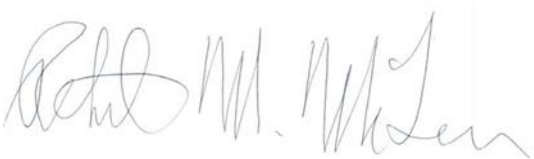
downstream impacts. For example, because of the necessary shift by practices to take care of more urgent or emergent issues rather than routine or preventive services, attribution for population-based models will be skewed to only the sickest patients. Hospital admissions will no longer be an accurate 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, insurers should consider completely eliminating claims data from calendar months significantly impacted by the virus from any performance and benchmark calculations.

- **Do not make network or coverage changes based on 2020 performance data.** Clinicians who do the most to help vulnerable patient communities during this outbreak will see the most significant negative impact to their performance.
- **Only post 2020 quality and cost information if it can be proven that COVID-19 has been appropriately accounted for in all risk adjustment, patient attribution, and calculation methodologies for all performance metrics.** If performance data for Medicaid clinicians is posted without appropriately adjusting for the impact of COVID-19, patients could draw unfair conclusions about a particular clinician or practice that could do long-lasting damage to one's reputation. Again, clinicians who do the most to treat COVID-19 patients and curb the pandemic could see the most damage to their reported performance.
- **Make temporary adjustments to or exclusion from recommended clinical practice guidelines as necessary to prevent the spread of COVID-19.** For example, it may be safer for patients with non-serious complications to avoid in-person visits at this time and be treated through a telehealth visit and self-monitoring at home instead.

In Conclusion

ACP is extremely thankful and encouraged by the actions taken by NAMD's members 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 Medicaid take additional emergency actions to adequately assist and prepare physicians and other clinicians with the resources and burden reduction they need to be successful in defeating 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,



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