



**Response from the  
American College of Physicians  
To the U.S. Senate Committee on Health, Education, Labor and Pensions  
On  
“Preparing for the Next Pandemic”  
June 26, 2020**

The American College of Physicians (ACP) is pleased to submit this response and appreciates that Chairman Alexander has invited information from the health-care community about what steps should be taken now to prepare the country for future pandemics. We applaud your commitment to pandemic preparedness and ACP appreciates that the Health, Education, Labor and Pensions Committee (HELP) has been holding hearings on this topic including most recently the June 17<sup>th</sup>, 2020, hearing entitled, “Telehealth: Lessons from the COVID-19 Pandemic” and the June 23<sup>rd</sup>, 2020, hearing entitled, “COVID-19: Lessons Learned to Prepare for the Next Pandemic”. We also hope that this important discussion will provide a platform to act on bipartisan solutions improving the nation’s capacity to confront the ongoing national public health emergency (PHE) caused by coronavirus disease 2019 (COVID-19) and more effectively contend with future pandemics. We wish to assist in the HELP Committee’s efforts by offering our input and suggestions to the white paper released by the committee entitled, “Preparing for the Next Pandemic”.

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.

We ask that the HELP Committee work in a collaborative bipartisan fashion to both respond to the continuing COVID-19 PHE and prepare for future pandemics as outlined in the committee’s white paper and urge you to include the following policy priorities:

- Ensure that the federal government has an adequate supply of vaccines and diagnostic testing in order stop the spread of COVID-19 or a future pandemic;
- Provide state and local authorities with enough resources from the federal government for effective allocation based on need to ensure sufficient testing capacity, contact tracing and the workforce needed for follow-up;
- Stockpile and maintain an adequate supply of personal protective equipment, vaccines, and antiviral treatments and build up health care system capacity to protect the U.S. population;

- Furnish direct financial support to practices to offset losses of revenue and increased costs, through at least the PHE if not longer so that patients can receive health care services and extend certain telehealth policies and waivers to remain in effect through at least the end of the ongoing COVID-19 PHE or longer to be ready for a future pandemic;
- Improve federal response and coordination during a Public Health Emergency (PHE) by increasing resources and prioritizing programs that a review of the evidence shows have been effective in promoting critical public health objectives;
- Invest in high-value primary care to expand coverage for all individuals.

## **Tests, Treatments, and Vaccines – Accelerate Research and Development**

### **Vaccines**

To address current and looming pharmaceutical therapies and vaccine shortages during a pandemic, ACP recommends that the federal government should work with pharmaceutical companies to ensure that there is an adequate supply of pharmaceutical therapies and vaccines to protect and treat the U.S. population.<sup>1</sup> ACP also supports measures to increase pandemic influenza vaccine and antiviral medications in the Strategic National Stockpile (SNS) as discussed below to prepare for a future pandemic.

ACP also supports measures to increase domestic production of vaccines and antiviral medications, including providing liability protections to decrease barriers to manufacturing while maintaining protections for individuals injured from the use of vaccines and antiviral medications.<sup>2</sup>

### **Diagnostic Testing**

The capacity to quickly and accurately diagnose cases of COVID-19 or a future pandemic is imperative for the successful implementation of a case-based intervention strategy to contain the spread of COVID-19 and other pandemics while partially or fully resuming economic and social activities.<sup>3 4</sup> The evidence suggests that the United States will need to “test 2 to 6% of the population per day, or between 5 and 20 million people per day.”<sup>5</sup> The federal government needs to adequately invest in the development of diagnostic testing to have enough tests available during a pandemic.

## **Disease Surveillance – Expand Ability to Detect, Identify, Model, and Track Emerging Infectious Diseases**

### **The Federal Government’s Role: What Is Needed?**

ACP recommends that the federal government provide state and local authorities with the resources, funding and effective distribution based on need to 1) ensure sufficient testing capacity, contact tracing and the workforce needed for follow-up, 2) personal protective equipment, 3) health system treatment capacity.

While state and local governments and public health authorities have the principal role in making decisions on mitigating COVID-19 and building up and sustaining health system capacity, the federal government must do all that it can to ensure sufficient funding and resources to allow such decisions to be made and implemented safely and effectively, resourced to high risk communities, and to

communities where surges may not yet have occurred but where resources are needed to control the spread of the virus early. ACP has said that the federal government must do more than it has done thus far to ensure that the required tests, workforce capacity, supplies, and PPE are available and distributed based on need.<sup>6</sup> ACP has also called on Congress and the administration to address drug shortages and price-gouging, and support for physician practices.

ACP recommends consideration of the recommendations made in an April 27, 2020, bipartisan letter from Mr. Andrew Slavitt, former CMS administration under President Obama's administration, Dr. Scott Gottlieb, former FDA Commissioner under President Trump's administration, and other former public officials and current non-governmental public health experts, calling on Congress to authorize and appropriate \$46.5 billion to successfully contain virus spread. They "propose Congress authorize and appropriate this funding in the form of block grants to states and territories twice annually based on plans they submit to the Department of Health & Human Services with their projected case counts, testing capabilities, and as they are available, data tools for functions such as immunization tracking." These monies would go to "expansion of the contact tracing workforce by 180,000 persons until such time as a safe, effective vaccine is on the market . . . (\$12 billion), voluntary self-isolation facilities utilizing vacant hotels in order to prevent infection spread (\$4.5 billion), income support for voluntary self-isolation (\$30 billion), and other purposes."<sup>7</sup>

ACP believes that funding levels and programs recommended by Dr. Gottlieb, Mr. Slavitt and the other authors represent a sound blueprint for Congress and the administration to provide the necessary resources to effectively and safely allow state and local authorities, businesses, and health care facilities to allow certain priority activities while effectively mitigating harm from a pandemic outbreak such as COVID-19.

### **Ensure Sufficient Funding and Coordination for Public Health Data Surveillance and Analytics Infrastructure Modernization**

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 remains concerned 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.

### **Communities Need to Have the Capability for Effective Contact Tracing with Privacy Protections**

ACP recommends ramping up traditional contact tracing measures and capabilities supplemented with complementary technology. Public-health infrastructure will need to be dramatically scaled up throughout the country by the addition of at least 100,000 trained contact tracers and the creation of a digital platform that enables effective tracking of testing, surveillance, and contact tracing across the country, while ensuring that sufficient individual privacy and confidentiality safeguards are in place.<sup>8 9</sup>

This workforce should be recruited from the communities served and trained to conduct contact tracing in a manner that is culturally and linguistically appropriate. This workforce will be strategically deployed to areas of greatest need and managed through state and local public health agencies in close coordination with regional healthcare facilities. Additional funding will be necessary to support implementation of safe quarantine practices for infected individuals and their contacts.<sup>10</sup>

ACP recommends that contact tracing and other practices to assist in public health surveillance be fully aligned with civil liberties, due process, non-discrimination, data and health privacy protections, and health ethics.<sup>11</sup>

ACP recommends that any uses of technology in the U.S. in the context of pandemic should be demonstrated to be effective, be temporary, and ensure safeguards for privacy and confidentiality are in place. ACP recommends that physicians and their care teams and patients should be actively involved in the development, testing, and implementation of any public health surveillance technology or application.

- Public health surveillance technologies or applications should be made equally available to everyone interested in using them in a non-discriminatory manner.
- There should be clear mechanisms in place regarding the governance and oversight of public health surveillance technologies and applications and developers should use open source coding approaches in order to allow for independent and regulatory audit.<sup>12 13</sup>
- The broader contact tracing workforce needs to be provided education and training regarding the ethics of public health data collection and use, how to properly manage public health data, risk communication, cultural sensitivity, and the specifics of local processes and data collection efforts.<sup>14</sup>
- Data collection and analysis infrastructures that are used in testing and surveillance should both prioritize connection to needed care for the individual user and provide support for COVID-19 decision making at the population-level to the extent possible, in order to help mitigate and ideally reduce disease spread.<sup>15</sup>
- All such technologies should first be tested in demonstration projects to the extent feasible due to the time-sensitive nature of this pandemic to assess the effectiveness and unforeseen consequences.<sup>16</sup> If implemented, they should constantly be monitored to determine their impact on disease mitigation, ideally based on predetermined measures that are developed with input from physicians and their care teams and patients.<sup>17</sup>
- Information on this impact should be shared publicly,<sup>18</sup> and mechanisms should proactively be put in place to shut down the use of a technology or app if it is deemed ineffective, unethical in its implementation, or no longer needed.<sup>19</sup>

ACP recommends that extensive safeguards must proactively be put into place in order to ensure user privacy and responsible data management by any public health surveillance technologies or applications.<sup>20</sup>

- These safeguards should be developed with input from the public and in partnership with other public and private efforts to improve transparency and trust with regard to privacy, encourage patients to seek testing and treatment, not exacerbate health disparities and should prioritize

the development of national educational campaigns and guidance on patient rights, physician responsibility and liability, and how to navigate the health data privacy landscape.<sup>21</sup>

ACP recommends that informed consent and opt-in should be required. Users of any public health surveillance technology must be provided with standard, transparent, and easily understandable notices of privacy practices that contain all permitted uses of the data.

- Users should be able to exercise choice at multiple levels, such as installing the app, allowing the app to operate in the background or only while open, receiving alerts from the app, and other functions.
- Consent models must be developed expeditiously and include, to the extent possible, input from the public, ethicists, civil rights experts, physicians and other clinicians, and health care and public health policy experts.
- Consent models must account for consumer literacy and preferred language, be patient-friendly, revocable, and unambiguous.
- Additionally, if consent is to operate effectively in a networked environment, health IT standards must be developed and consistently implemented so that it is clear that the consent is tied to the health information to which it applies.<sup>22 23</sup>

ACP believes that public health surveillance technologies or applications may be useful as supplemental tools, in the context of a broader approach to mitigation and contact tracing, as they can act as a “force multiplier” to connect with many more people in a community.<sup>24</sup> While such technologies used to assist in public health surveillance efforts for COVID-19, including for the purposes of mitigation and contact tracing hold promise, they also raise privacy, confidentiality, and other issues. They may have benefits, but the effectiveness of such approaches is not yet proven. In some countries, technology-assisted contact tracing has proven to be very problematic with data collected on location, immigration status, transit use, personal and health records, and credit transactions, along with reporting to police and many government agencies.<sup>25</sup> These approaches are not acceptable and should be expressly avoided.

### **Stockpiles, Distribution, and Surges – Rebuild and Maintain Federal and State Stockpiles and Improve Medical Supply Surge Capacity and Distribution**

#### **Stockpile and maintain supply of Personal Protective Equipment**

ACP believes that the federal government should use all possible means to ensure that there is sufficient funding, manufacturing, supply, and distribution capacity to get Personal Protective Equipment (PPE) immediately to every physician, nurse, and health worker not only on the front lines of caring for patients who may be infected due to a pandemic, but as well as those individuals caring for patients in general. The Strategic National Stockpile (SNS) needs to procure sufficient enough pharmaceuticals, personal protective equipment (PPE), and other medical supplies, which can be distributed to State and local health agencies in areas with shortages during a pandemic. However, the grim reality was that frontline health care workers were not able to get the PPE they needed to protect themselves and their patients during the COVID-19 pandemic and some shortages remain ongoing. Nothing can be more urgent than rapidly increasing the supply and distribution of PPE during the opening days of a pandemic.

In addition, the use of the Defense Production Act to require the manufacture of PPE should be invoked early on during a pandemic to protect physicians, nurses, and other frontline health care workers. As we saw during the current PHE, such action was sorely needed to address the COVID-19-induced shortage of masks, gowns, gloves, and other PPE that put frontline medical professionals who were caring for patients at grave risk of becoming infected and sickened by the virus, and then spreading it to colleagues, family members, and patients.

### **Stockpile and maintain supply pandemic flu vaccine and antiviral medications**

ACP also supports measures to increase pandemic influenza vaccine and antiviral medications in the SNS. ACP supports the national procurement of vaccine in an amount sufficient to protect the entire U.S. population and national procurement of antiviral medications to cover 25% of the U.S. population. ACP believes that additional courses of antiviral medications should be safeguarded in the Strategic National Stockpile for all public safety officers and health care workers with direct patient contact in amounts sufficient to provide prophylaxis. In the event of pandemic influenza, stockpiled vaccine and antivirals should be distributed equitably to all states' public health authorities based on the numbers of people in high-risk and high-priority groups.<sup>26</sup>

### **Communities Need to Have Appropriate Health Care System Capacity**

ACP recommends the development of a national implementation strategy to ensure adequate healthcare system capacity during periods of surge and availability of personnel protective equipment for all physicians and other clinicians and health care workers. This includes staffed hospital and critical care beds and post-hospitalization capacity in long term and extended care facilities, skilled nursing facilities, rehabilitation centers, and primary care. In addition, this requires that supply chains remain intact so that key health care resources including trained personnel, essential testing materials, personal protective equipment, ventilators, CVVH/dialysis machines, essential medications, and other supplies are allocated and redirected based on need.<sup>27 28 29</sup> The national strategy must be developed, implemented and coordinated with input from state and local authorities, supply chain managers, private industry, and health care systems to assure that resources reach areas that need them including financially disadvantaged communities with pre-existing health care disparities.

### **Public Health Capabilities – Improve State and Local Capacity to Respond**

#### **In-Person Medical Care Visits and Other Health Care Services: What Is Needed?**

Before patients can go back to their healthcare routine safely, with the assistance of the federal government, communities should have in place the testing, contact tracing, health system capacity, communications plans, as decisions are made by public health authorities, physicians, and health care facilities on gradually resuming in-person medical care visits and other health care services that were temporarily suspended or delayed to mitigate the spread of the pandemic and free up accessible resources to treat the virus.

In order for patients to go back to their routine health care safely, and develop better plans for the future so that doctors and hospitals can continue to provide health care services and outpatient treatment during a pandemic, ACP recommends that public and private payers provide direct financial

support to practices to offset losses of revenue and increased costs, through at least the PHE if not longer, even as they begin to resume in person visits. ACP has recommended that both Congress and the Centers for Medicare and Medicaid Services (CMS) provide funding to physician practices to offset the substantial revenue losses they have incurred as they moved from in-person visits to mostly virtual visits (telehealth and phone calls with patients).<sup>30</sup> Yet even as many physician practices have received emergency funding from the federal government, many remain at risk of closing their doors due to substantial reductions in revenue and patient volume.<sup>31</sup> Primary care practices are particularly at risk.<sup>32</sup> Internal medicine specialists providing preventive, primary and comprehensive care, including internal medicine subspecialists caring for patients with complex chronic illnesses, are at risk of having their practices close without more support.

Even when practices are able to safely begin seeing more patients back in the office, it is likely that they will be seeing fewer patients in the office than in the past, adjusting scheduling to reduce the risk of COVID-19 transmission, and will continue to see many patients via telehealth and phone calls. Patients may also be reluctant to go into a physician's office. Direct financial support payments to primary care will continue to be necessary to keep practices open.

ACP recommends that ambulatory internal medicine practices start planning how they might safely and effectively begin to resume in-person visits that have been temporarily suspended or postponed during a pandemic. Rigorous infection control protocols including availability and use of personal protective equipment for staff and patients, physical distancing measures, facility and equipment sterilization procedures, and frequent hand washing/sanitization are essential to ensure patient and staff safety. In addition, staff will need to be screened daily for fever and COVID-19 symptoms prior to in-person contact with patients and should undergo periodic testing based on availability. ACP supports the recommendation from CMS that practices should make every effort to maximize the use of telephone and video visits in order to limit in person visits to those necessary for clinical decision making and/or treatment.<sup>33</sup>

ACP recommends that physicians, practices, and health care facilities consider the use of innovative workflows and schedules designed to minimize contact between patients and staff. Examples include: asking staff engaged in activities like scheduling, billing, and telemedicine to do so remotely; "no touch" patient check in and text notification for patients to proceed directly to the exam room, physically distanced waiting rooms (or close and repurpose waiting rooms); staggered scheduling of mini-teams of staff; separate scheduling of COVID-19 follow up visits and respiratory clinics and many others. ACP recommends that practices select innovative workflows they think might work best in their settings, to try them and commit to the ongoing sharing of best practices with one another.

### **Ensuring that the gains made in telehealth during the COVID-19 pandemic are not lost**

Internal medicine specialists have an essential role in delivering primary, specialty, preventive and comprehensive care not only to patients with symptoms or diagnoses of COVID-19, but also to patients with other underlying medical conditions, including medical conditions like heart disease and diabetes that put them at greater risk of mortality from COVID-19. During the Coronavirus pandemic, they have continued to deliver care to their patients with the expanded utilization of telehealth made possible by new policies either enacted by Congress or through the U.S. Department of Health and Human Services

(HHS). However, many of the telehealth flexibilities and policy changes made by Congress and HHS are due to expire at the conclusion of the PHE, wherein patients and physician practices would be expected to revert back to primarily face-to-face services without any type of risk-based assessment for gradually reopening medical practices and health systems to care for non-COVID and non-acute patients.<sup>34</sup> This quick reversal in policy does not take into account patients' comfort level in returning to physician offices to seek necessary care, as well as changes in office workflow and scheduling practices to mitigate spread of the virus within practices resulting in substantially lower volume of in-person visits for as long as the pandemic is with us. Therefore, the quick reversal in policy is not an effective way to recover from the PHE, nor prepare for possible future outbreaks. The College believes that the patient care and revenue opportunities afforded by telehealth functionality will continue to play a significant role within the U.S. healthcare system and care delivery models, even after the PHE is lifted. In order to address the many barriers to patient access and physician adoption and use of telehealth prior to the COVID-19 pandemic, and properly assess how to foster and strengthen longitudinal, patient-centered care delivery, ACP believes there are a number of interim policies that should remain in effect for a period of time after the PHE is lifted. **Specifically, the following policies and waivers should remain in effect through at least the end of 2021, or until such a time when effective vaccines and treatments are widely available, with an option to extend even further, or consider making permanent to prepare for the next pandemic, based on the experiences and learnings of both patients and physicians utilizing these revised policies:**

#### **Pay Parity for Audio-Only and Telehealth Services**

The College wholeheartedly supports the Centers for Medicare and Medicaid Services' (CMS) actions to provide additional flexibilities for patients and their doctors by providing payment for telephone services during COVID-19 pandemic. These changes in payment policy address some of the biggest issues facing physicians as they struggle to make up for lost revenue and provide appropriate care to patients. **The College strongly recommends that pay parity between telephone claims and in-person visits and between all telehealth and in-person visits be maintained after the PHE is lifted. This extension—either continued by CMS or mandated by Congress—should last 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 it even further, or consider making permanent to contend with next pandemic, based on the experience and learnings of patients and physicians who are utilizing these visits.**

Evidence shows that patient visits to ambulatory practices have declined significantly and despite a rebound, visits remain 30 percent lower than they were pre-pandemic<sup>35</sup>, with utilization for practice areas such as adult primary care declining by well over 60 percent.<sup>36</sup> Given the uncertainty around the timeline for a COVID-19 vaccine or treatment, many expect that the virus will continue to spread well into 2021. Therefore, as the need to contain the virus and maintain appropriate social distancing protocols continues into next year, it is unlikely that in-person visits to practices will return to pre-pandemic levels as patients remain uncomfortable with making these in-person visits and physicians schedule fewer patients to be seen in the office. Additionally, the HHS Office of Civil Rights (OCR) announcement regarding enforcement discretion around non-HIPAA-compliant technologies during the PHE has shown to be useful in allowing physicians to quickly shift their predominately in-person practices to more virtual care, as well as allowing increased access by patients to more widely available technologies. **Due to the long-lasting effects of the pandemic, and the need for physician practices to**



**maintain the ability to provide care virtually, ACP recommends Congress urge OCR to maintain this enforcement discretion after the PHE is lifted, or until effective vaccines and treatments are widely available.**

**ACP also urges Congress to establish uniform policy for all payers that reimburses all services furnished via telehealth and audio-only taking place between patients and their own physicians on par with in-person services for both new and established patients.** Practices are struggling to keep their doors open during this pandemic; time spent monitoring for constant updates on individual payer policies is time that could be devoted to direct patient care or slowing the spread of the disease. We are also concerned that many health plans are restricting full payment parity for telehealth and telephone services to propriety platforms. **Therefore, the College further calls on Congress to require that all payers allow the use of non-public facing synchronous video platforms, such as Skype and FaceTime—in order to offer patients and physicians more options to ensure effective and efficient virtual care during and ideally beyond the PHE.**

### **Geographical Site Restriction Waivers**

ACP strongly supported CMS' policy changes to pay for services furnished to Medicare beneficiaries in any healthcare facility and in their home — allowing services to be provided in patients' homes and outside rural areas. ACP has long-standing policy in support of lifting these geographic site restrictions that limit reimbursement of telehealth services by CMS to those that originate outside of metropolitan statistical areas or for patients who live in or receive service in health professional shortage areas.<sup>37</sup> While limited access to care is prevalent in rural communities, it is not an issue specific to rural communities alone. Underserved patients in urban areas have the same risks as rural patients if they lack access to in-person primary or specialty care due to various social determinants of health such as lack of transportation or paid sick leave, or sufficient work schedule flexibility to seek in-person care during the day, among many others. The funding provided through the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) to the Federal Communications Commission (FCC), and other efforts through the FCC to expand access to telehealth services, offer the opportunity to provide the technologies and broadband needed for these underserved patient populations to utilize these services. **Accordingly, it is essential to maintain expanded access to and use of telehealth services for these communities, as well as rural communities, and ACP recommends that Congress permanently extend the policy to waive geographical and originating-site restrictions after the conclusion of the PHE which would aid in treating patients during a future pandemic.**

### **Telehealth Cost-Sharing Waivers**

ACP appreciated the flexibility provided by CMS to allow clinicians to reduce or waive cost-sharing for telehealth and audio-only telephone visits for the duration of the PHE. At the same time, we call on CMS or preferably Congress to ensure that they make up the difference between these waived copays and the Medicare allowed amount of the service. Many practices are struggling or closing. It is critical that CMS and other payers not add to the financial uncertainties already surrounding these physicians. Given the enormity of the COVID-19 pandemic, cost should not be a prohibitive factor for patients in attaining treatment. This critical action has led to increased uptake of telehealth visits by patients. At the conclusion of the COVID-19 PHE, ACP recommends that Congress (or CMS) continue to provide flexibility in the Medicare and Medicaid programs for physician practices to reduce or waive cost-

sharing requirements for telehealth services, while also making up the difference between these waived copays and the Medicare allowed amount of the service. **This extension should last 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 it even further based on the experience and learnings of patients and physicians who are utilizing these visits to also prepare for the next pandemic.** This action in concert with others has the potential to be transformative for practices while allowing them to innovate and continue to meet patients where they are.

#### **Revised Policies for Remote Patient Monitoring Services**

CMS finalized policy that now allows remote patient monitoring (RPM) to be used for both new and established patients. The agency also notes that consent to receive RPM services can be obtained once annually, including at the time services are furnished for the duration of the PHE for the COVID-19 pandemic.

The College supports expanded access to RPM by allowing physicians to utilize them for both new and established patients during the PHE. We also welcome the burden reduction attained by allowing patients to consent to these services once annually. Additionally, the decision by the CMS to allow RPM to be used for both acute and chronic conditions further expands access to these services at this important time when patients and their care teams need additional resources to meet the current challenges. These changes will help to relieve physician burden and allow physicians more time to treat the more complex patient issues that require more than remote monitoring. **We encourage Congress (or CMS) to maintain these modifications 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 it even further, or consider making permanent, based on the experience and learnings of patients and physicians who are utilizing these services. ACP also asks Congress to require that all payers implement these recently finalized CMS flexibilities for RPM services.**

#### **Interstate Licensure Flexibility for Telehealth and Promotion of State-Level Action**

ACP supports a streamlined approach to obtaining several medical licenses that would facilitate telehealth services across state lines while allowing states to retain individual licensing and regulatory authority.<sup>38</sup> We appreciated CMS' temporary waiver allowing physicians to provide telehealth services across state lines, as long as physicians meet specific licensure requirements and conditions. **ACP recommends that Congress keeps these changes in place 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 it even further based on the experience and learnings of patients and physicians who are utilizing these flexibilities, including extending these flexibilities to help preparation for the next pandemic.** These waivers offer an opportunity to assess the benefits and risks to patient care in addressing the pandemic as well as the ability to maintain longitudinal care for patients who move across state lines. While these waivers do not supersede any state or local licensure requirements, they provide the opportunity to promote state-level action that may further promote more streamlined licensure requirements across the country.

## **Improve Coordination of Federal Agencies During a Public Health Emergency**

In order to meet the needs of the ongoing COVID-19 pandemic and to be prepared for the next pandemic, ACP supports investing in the nation's public health infrastructure. Priority funding should be given to federal, state, tribal, and local agencies that serve to ensure that the health care system is capable of assessing and responding to public health needs. The College is greatly concerned that recent and proposed reductions in funding for agencies responsible for public health are posing a grave risk to the United States' ability to ensure the safety of food and drugs, protect the public from environmental health and infectious risks, prepare for natural disasters and bioterrorism, and provide access to care for underserved populations. Congress must prioritize federal funding to ensure that federal agencies responsible for public health, including the National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), Food and Drug Administration (FDA), Health Resources and Services Administration (HRSA), the Agency for Healthcare Research and Quality (AHRQ), the U.S. Department of Agriculture (USDA), the Environmental Protection Agency (EPA), and the Substance Abuse and Mental Health Services Association (SAMHSA), are given sufficient resources to carry out their public health missions. **Efforts should be made to ensure better coordination of public health initiatives across federal agencies and to reduce wasteful duplication and inefficiencies resulting from poor coordination of their activities.**<sup>39</sup>

It is particularly important that in order to be prepared for the next pandemic that federal, state, tribal, and local agencies prioritize and appropriately allocate funding to programs that have the greatest need for funding and the greatest potential benefit to the public's health. All programs that receive funding should be required to provide an ongoing assessment of their effectiveness in improving population health. ACP recommends that priority for funding be given to programs based on their effectiveness in improving the health of the public. **Specifically, ACP recommends that funding priority should go to programs that a review of the evidence shows have been effective in promoting critical public health objectives such as:**

- Support safety net facilities and local health departments;
- Reduce health care disparities relating to racial and ethnic characteristics, cultural differences, socioeconomic, and language and literacy barriers; and
- Educate clinicians and the public on disaster preparedness, to ensure sufficient "first-responder" capacity and training, and to ensure that there is sufficient "surge capacity" at hospitals and physician offices to address a public health emergency.<sup>40</sup>

## **Invest in High Value Primary Care to be Ready for the Next Pandemic**

Investing in primary care is critical not only to overall patient health but also to the reduction of costs in the health care system. The National Academy of Medicine defines primary care as "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community." In a pandemic, such as the one we are seeing now, it is even more imperative that all people have access the kind of coverage described above. Below, ACP recommends policies that can be implemented to expand quality coverage, either through new programs or building on existing ones.

## **Universal Coverage**

In order to be prepared for a future pandemic, ACP recommends that the United States transition to a system that achieves universal coverage with essential benefits and lower administrative costs. Coverage should not be dependent on a person's place of residence, employment, health status, or income. Coverage should ensure sufficient access to clinicians, hospitals, and other sources of care. Two options could achieve these objectives: a single-payer financing approach, or a publicly financed coverage option to be offered along with regulated private insurance.<sup>41</sup>

ACP also recommends that under either a public choice or single-payer model, coverage must include an essential health care benefit package that emphasizes high-value care, preferably based on recommendations from an independent expert panel that includes the public, physicians, economists, health services researchers, and others with expertise.<sup>42</sup>

ACP believes that, whether a public choice or single-payer or model, cost sharing that creates barriers to evidence-based, high-value, and essential care should be eliminated, particularly for low-income patients and patients with certain defined chronic diseases and catastrophic illnesses. In general, when cost sharing is required for some services, it should be income-adjusted through a subsidy mechanism and subject to annual and lifetime out-of-pocket limits. In a public choice model, premiums should be income adjusted and capped at a percentage of annual income.<sup>43</sup>

In either a public choice or single-payer model, payment rates to physicians and other clinicians, as well as to hospitals and other facilities that offer health care services, must be sufficient to ensure access to needed care and should not perpetuate disparities in current payment methods. Current Medicare payment rates generally are insufficient to achieve the objectives of universal coverage. Physician payment policies must ensure robust participation and not undervalue primary care and cognitive services, including the primary, preventive, and comprehensive care provided by internal medicine physician specialists.<sup>44</sup>

## **Reducing Excessive Pricing and Improving Efficiency**

ACP strongly supports efforts to reduce excessive list prices for goods and services, reduce price variation not associated with differences in the cost of providing services, reduce administrative costs at the system level and at the point of care, and improve the efficiency of the health care system. ACP believes that there is an immediate need for policy changes to slow spending growth, primarily in health care administrative costs, prescription drug pricing, and low-value care. Highly variable pricing for public and private payers as well as patients also need to be addressed.<sup>45</sup> However, the actual physician payment and the policies surrounding those payments must ensure robust participation and not undervalue primary care and cognitive services, including the primary, preventive, and comprehensive care provided by internal medicine physician specialists. Payment rates to physicians and other clinicians, as well as to hospitals and other facilities that offer health care services, must be sufficient to ensure access to needed care and should not perpetuate disparities in current payment methods.<sup>46</sup>

### **Ensure continued and sufficient federal funding to support Medicaid expansion as currently available**

In lieu of a public choice or single payer model, Congress must continue to preserve the federal government's contribution to Medicaid including the higher match for expansion states. In the 37 states and the District of Columbia that have agreed to expand Medicaid to persons with incomes up to 138 percent of the federal poverty level (FPL) millions of people have gained coverage who otherwise would not have been eligible for coverage prior to expansion. Studies show that they have gained access to care and financial security as a result, and initial data also show that expansion is associated with improvements in measures of self-reported health status. Yet because 14 states have not yet expanded Medicaid, an estimated millions of people fall in a "coverage gap" because they have incomes at or below 100% of the FPL, making them ineligible for the Affordable Care Act's premium and tax credit subsidies to purchase private insurance through the exchanges. For them, Medicaid expansion may be the only option to obtain coverage. States that have not yet expanded Medicaid should do so. **Congress should ensure that higher federal match for Medicaid expansion is not eliminated or phased out, and that non-expansion states can continue to join the program at their own option. Whether during the ongoing COVID-19 pandemic, or a future one, Congress should ensure that states continue to expand Medicaid so that there are no gaps in coverage during a pandemic.**

### **Continue increased Federal Matching Assistance Percentage**

ACP urges Congress to extend and/or increase the temporary 6.2 percent increase in the Federal Match Payment for certain Medicaid spending contained in the Families First Coronavirus Response Act, H.R. 6201, and the CARES Act, H.R. 748, past the duration of the public health emergency caused by COVID-19. State economies are sustaining a massive decrease in revenues during the COVID-19 public health emergency and the Federal Matching Assistance Percentage (FMAP) increase provides a welcome cash infusion. The extra funding is especially important as Medicaid enrollment is expected to increase during the pandemic. Estimates are that states would save over \$40 billion with the FMAP boost, with larger states like California and Florida receiving more federal money. Lower-income states would see their FMAPs rise to about 84 percent. The higher FMAP should be extended and/or increased as state budgets will need sufficient time to stabilize after the COVID-19 public health emergency ends. **Congress should continue to keep an increased FMAP in its toolkit for immediate help to states for when Medicaid enrollment rises during a pandemic.**

### **Medicaid Parity with Medicare**

ACP recommends that Congress 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. 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 the Kids Access to Primary Care Act, H.R. 6159. 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, which would also help to expand coverage during future pandemics.**

## **Conclusion**

We commend you for working in a bipartisan fashion to hopefully develop legislative proposals to combat the ongoing Coronavirus crisis—as well as future pandemics—through consideration of policies that can be enacted during the 116<sup>th</sup> Congress. We wish to assist the HELP Committee’s efforts in this area by offering our input and suggestions about ways that Congress and federal health departments and agencies can intervene through evidence-based policies to continue preparedness for the next pandemic. Thank you for consideration of our recommendations that are offered the spirit of providing the necessary support to physicians and their patients going forward. Please contact Jared Frost, Senior Associate, Legislative Affairs, by phone at (202) 261-4526 or via email at [jfrost@acponline.org](mailto:jfrost@acponline.org) with any further questions or if you need additional information.

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