Statement for the Record
American College of Physicians
To the United States Senate Committee on Health, Education, Labor and Pensions
On
"Examining Our COVID-19 Response: An Update from the Frontlines"
March 9, 2021

The American College of Physicians (ACP) is pleased to submit this statement and offer our views regarding the response to the public health emergency (PHE) caused by Coronavirus (COVID-19). We greatly appreciate that Chair Murray, Ranking Member Burr, and the Health, Education, Labor and Pensions (HELP) Committee has convened this hearing, "Examining Our COVID-19 Response: An Update from the Frontlines", held on March 9, 2021. Thank you for your shared commitment to ensuring that clinicians have the opportunity to share their views about the response to the PHE caused by COVID-19. Through the experiences of its physicians on the frontlines of furnishing primary care during the COVID-19 pandemic, ACP has consistently provided input and recommendations to lawmakers surrounding the ongoing need for personal protective equipment (PPE), increased support for the frontline physician workforce, adequate funding for COVID-19 testing, contract tracing, and vaccine distribution, and continued telehealth expansion. Support for these policies is vital to the pandemic response effort now after the national PHE comes to an end.

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 163,000 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.

Personal Protective Equipment
The various coronavirus relief packages, including the recently enacted American Rescue Plan Act (ARP), H.R. 1319, began and now continue to provide desperately needed personal protective equipment (PPE) to frontline physicians, nurses and other health care workers. The ARP included possible PPE funding in several provisions, including the use of the Defense Production Act (DPA) for procurement of supplies and services including PPE. However, ACP members and internists and other frontline health care workers are still experiencing difficulty in obtaining some types of PPE. Accordingly, ACP has continued its financial contributions that will help Project N95 to secure appropriate inventory levels for PPE, particularly for hard-to-obtain items such as nitrile gloves.

ACP has partnered with Project N95 since June 2020 to provide PPE for internal medicine physicians, filling an urgent need for frontline ACP member physicians during the COVID-19 pandemic. Since the beginning of the pandemic ACP has been vigorously advocating for the need for adequate PPE, calling on suppliers and the federal government to ensure the availability of essential PPE to protect frontline physicians. Many individual physicians, especially those outside of hospitals, had been closed out of ordering PPE through distributors at reasonable prices and quantities.

Despite recent reports that U.S. suppliers of N95 respirators have inventory available, the distribution system in the U.S. is still not working effectively enough to allow individual physicians to order high-quality PPE to meet their needs. ACP is continuing to see members needing to order PPE through our distribution partnership with Project N95, which is why we continue to provide financial support to Project N95. The demand crunch has shifted from N95 respirators to nitrile patient exam gloves, with gloves being the latest example of a product where the minimum order quantities are so high that only the largest distributors can easily compete for inventory supplies.

The need still exists for ACP to offer an alternative buying channel for our members, which we are doing through Project N95, but the need has declined significantly since last summer. Sales of N95 respirators through ACP declined 50 percent from August to December, and declined 34 percent from December to January and February. However, we still have hundreds of members buying through ACP and Project N95.

Support Frontline Physician Workforce

Primary care physicians, including internal medicine specialists, continue to serve on the frontlines of patient care during this pandemic with increasing demands placed on them. During the pandemic's worst months, there was an increasing reliance on medical graduates, both U.S. and international, to serve on the frontlines in this fight against COVID-19. Many residents and medical students played a critical role in responding to the COVID-19 crisis and providing care to patients on the frontlines. For residents, COVID-19 has inflicted additional strain on them as they were redeployed from their primary training programs and put onto the frontlines to care for the sickest patients, often putting their own health at risk, and many without appropriate PPE at the time. ACP recommends the following legislation from the previous, 116th Congress, that should be reintroduced and passed in the current 117th Congress to assist medical graduates and the overall physician workforce:

- **Conrad State 30 and Physician Access Reauthorization Act, H.R. 2895, S. 948, (116th Congress)**: This bill allows states to sponsor foreign-trained physicians to work in medically underserved areas in exchange for a waiver of the physicians' two-year foreign residence requirement. It increases the base number of annual Conrad waivers available to each state from 30 to 35, with a demand-based sliding scale to determine the number of available waivers in future years, and includes a provision to address the current backlog in the system for physicians on J-1 visas who wish to acquire permanent residency status (green card).
- **Healthcare Workforce Resilience Act, H.R. 6788, S. 3599, (116th Congress)**: This bill would authorize immigrant visas for health care clinicians, including up to 15,000 physicians who are eligible to practice in the United States or are already in the country on temporary work visas. The visas would provide a pathway to employment based green cards. View ACP's letter of support to Congress for S. 3599 in the 116th Congress.

- **The Student Loan Forgiveness for Frontline Health Workers Act, H.R. 6720, (116th Congress):** This bill would forgive student loans for physicians and other clinicians who are on the frontlines of providing care to COVID-19 patients or helping the health care system cope with the COVID-19 public health emergency.

COVID Testing, Contact Tracing, Treatment and Vaccines

ACP strongly supported several provisions in the American Rescue Plan (ARP) Act of 2021, H.R. 1319, that directly will help to contain the COVID-19 pandemic. ACP supported the provisions in the ARP to provide $49 billion to HHS to detect, diagnose, trace, and monitor COVID-19 infections, and for other activities necessary to mitigate the spread of COVID-19 in the. ACP also supported the ARP provisions to require Medicaid coverage of COVID-19 vaccines and treatment without beneficiary cost sharing with vaccines matched at a 100 percent federal medical assistance percentage (FMAP) through one year after the end of the PHE. It also gives states the option to provide coverage to the uninsured for COVID-19 vaccines and treatment without cost sharing at 100 percent FMAP. ACP is pleased that these provisions help cover vulnerable populations during the PHE caused by COVID-19.

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. 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.

Accordingly, ACP strongly supported the provisions in the ARP to provide $7.5 billion in funding for the Centers for Disease Control and Prevention (CDC) to prepare, promote, administer, monitor, and track COVID-19 vaccines, and $6 billion to the Department of Health and Human Services (HHS) to support advanced research, development, manufacturing, production and purchase of vaccines, therapeutics, and ancillary medical products utilized for treatment and prevention of COVID-19. ACP is also appreciative of the $1 billion in the ARP for vaccine confidence activities to promote education and increase vaccination rates.

ACP supports requirements that COVID-19 vaccines be provided at no cost to all patients, regardless of coverage status. ACP supports an all-hands-on deck approach to administer COVID vaccines, which includes primary care offices. **We urge Congress to work with the administration, state and local governments, and vaccine distributors to support physicians who wish to administer the COVID-19 vaccine by ensuring community-based practices are included in distribution plans. In a January 2021 survey, 71 percent of medical practices reported being unable to obtain COVID-19 vaccine for their patients, and independent medical groups were significantly less likely to have access than those owned by hospitals or health systems.** It is vital that vaccinators record the vaccine administration data within the patient's medical record and promptly report to the state's immunization information system (IIS) or other designated CDC system. Ideally, health IT systems would automate vaccination data sharing with minimal additional

effort required, including reporting to state IISs and notifying the patient's primary care team of their vaccination status and other relevant information.

Continuing Telehealth Expansion

ACP strongly supports the expanded role of telehealth as a method of health care delivery that may enhance patient–physician collaborations, improve health outcomes, increase access to care and members of a patient's health care team, and reduce medical costs when used as a component of a patient's longitudinal care. Telehealth can be most efficient and beneficial between a patient and physician with an established, ongoing relationship and can serve as a reasonable alternative for patients who lack regular access to relevant medical expertise in their geographic area. Primary care physicians have had to convert in-person visits to virtual ones in response to the COVID-19 PHE, and practices are experiencing huge reductions in revenue while still having to pay rent, meet payroll, and meet other expenses without patients coming into their practices.

During the Coronavirus pandemic, internal medicine specialists continue to deliver care to their patients with the expanded utilization of telehealth made possible by new policies either enacted by Congress, the U.S. Department of Health and Human Services (HHS), as well as private payers. 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.[1] 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. Please see ACP's response to the HELP Committee for the committee's June 17, 2020, hearing, "Telehealth: Lessons from the COVID-19 Pandemic" and more recently ACP's statement to the House Committee on Energy and Commerce's March 2, 2021, hearing, "The Future of Telehealth: How Covid-19 is Changing the Delivery of Virtual Care". 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 that the following existing PHE flexibilities and waivers should be continued—and not allowed to expire—to support making telehealth an ongoing and continued part of medical care now and in the future, allowing time for further evaluation on which ones should be maintained**

[1] Doherty R., Erickson S., Smith C., Qaseem A. "Partial Resumption of Economic, Health Care and Other Activities While Mitigating COVID-19 Risk and Expanding System Capacity." American College of Physicians, May 6, 2020: https://www.acponline.org/acp_policy/policies/acp_guidance_on_resuming_economic_and_social_activities_2020.pdf

as is, revised or expanded:

- **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. 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. Primary care services delivered via telephone have become essential to a sizable portion of Medicare beneficiaries who lack access to the technology necessary to conduct video visits. ACP is discouraged to learn that CMS will not continue coverage of telephone evaluation and management (E/M) services beyond the PHE, despite mounting evidence about the effectiveness of expanding coverage for these services. While ACP has supported the Agency's actions to provide coverage and payment parity for such telephone services, the College is very concerned about the impact of reversing these changes at the conclusion of the PHE. **ACP believes that existing PHE flexibilities and waivers should be continued, and not be allowed to expire—including pay parity for audio-only phone calls—to support making telehealth an ongoing and continued part of medical care now and in the future, allowing time for further evaluation on which ones should be maintained as is, revised or expanded. We also urge removal of the requirement for the use of two-way, audio/video telecommunications technology so that telephone E/M services can continue to be provided to Medicare beneficiaries.**
- **COVID-19 Vaccine Counseling:** Although most community-based physician practices are not yet administering COVID-19 vaccinations, many report providing significant counseling and risk factor reduction services to patients who are concerned about COVID-19 or who are trying to get vaccinated against the virus. However, coding and payment has not been made available to allow physicians to bill for these services. While office visit E/M visits, telephone E/M, virtual check-ins, and e-visits have been made available by CMS during the pandemic to provide for virtual care, these coding options are not sufficient to meet the current needs. Specifically, the E/M visits are not available for billing as no diagnoses have been established to necessitate an E/M visit. Patients are calling for advice from their doctors, not to set up a visit for a medical problem/issue they are experiencing. Additionally, virtual check-ins are an ineligible option as they are for patients seeking to determine whether an E/M visit is necessary. In the case of COVID-19 vaccinations, patients are seeking to understand the risks associated with getting a COVID-19 vaccine, and where to find a vaccine. These are not examples of patients checking in with their physician to understand whether an office visit is necessary. It is merely for advice and counseling. **ACP recommends that Congress urge, or if necessary, require CMS to make coding and payment available for time spent by physicians providing counseling services to patients who are seeking to mitigate their risk for COVID-19 infection. Specifically, ACP encourages CMS to make payment and coverage available for CPT code 99401 (Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes), wRVU 0.48. The College believes that this code adequately describes the resources and physician work involved in providing counseling and risk factor reduction services to patients with inquiries about COVID-19. We encourage CMS to temporarily make payment available for this code through at least December 31, 2021 and waive the face to face requirement associated with this service.**

- **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.[2] 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.[3] **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.**
- **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 urge, or if necessary require, CMS to 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 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. ACP believes that existing flexibilities and waivers should be continued, and not be allowed to expire, to support making telehealth an ongoing and continued part of medical care now and in the future, allowing time for further evaluation on which ones should be maintained as is, revised or expanded.**
- **Flexibilities in Direct Supervision by Physicians at Teaching Hospitals:** CMS has noted that in instances where direct supervision is required by physicians and at teaching hospitals, the agency will allow supervision to be provided using real-time interactive audio and video technology through the calendar year 2021. The College welcomes this decision by the agency to allow attending physicians and residents/fellows the ability to communicate over interactive systems asynchronously by waiving the in-person supervision requirement. This important step promotes efficient patient care and allows physicians and supervisees to work together

[2] Daniel H, Snyder Sulmasy L. "Policy Recommendations to Guide the Use of Telemedicine in Primary Care Settings." American College of Physicians, November 17, 2015: https://www.acpjournals.org/doi/full/10.7326/M15-0498

[3] Webb Hooper M, Nápoles AM, Pérez-Stable EJ. "COVID-19 and Racial/Ethnic Disparities." JAMA. Published online May 11, 2020. doi:10.1001/jama.2020.8598

unencumbered by social distancing restrictions**. We encourage Congress to urge, or if necessary require, CMS to maintain these modifications, and not allow them to expire.**

- **Revised Policies for Remote Patient Monitoring Services:** CMS finalized policy stating that following expiration of the COVID-19 PHE, there must be an established patient-physician relationship for RPM services to be furnished – ending its interim policy permitting RPM services to be furnished to new patients. The Agency also finalized policies allowing consent to receive RPM services to be obtained at the time RPM services are furnished and noted that practitioners may furnish RPM services to patients with acute conditions as well as patients with chronic conditions. RPM services have been a critical component of care, especially during the COVID-19 pandemic. ACP is pleased to see the Agency finalized a number of policies that will be beneficial to both patients and their care teams. These changes expand access to services at an important time, as patients and their care teams need additional resources to meet current challenges. These changes will help relieve physician burden and allow physicians more time to treat complex patient issues that require more than remote monitoring. We continue to believe that Congress should urge, and if necessary, require, CMS to extend the interim policy to allow RPM services to be furnished to patients without an established relationship.
- **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.[4] We appreciated CMS' temporary waiver allowing physicians to provide telehealth services across state lines, as long as physicians meet specific licensure requirements and conditions. 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. ACP also supports the Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act, S. 168, H.R. 708, which would provide temporary licensing reciprocity for telehealth and interstate health care treatment.

Conclusion

We commend you and your colleagues for working in a bipartisan fashion to develop legislative proposals to combat the ongoing Coronavirus crisis—as well as future pandemics—through continuing innovative policies. We wish to assist in 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 both now and beyond the PHE. Thank you for consideration of our recommendations that are offered in the spirit of providing the necessary support to physicians and their patients going forward. Please contact Jared Frost, Senior Associate, Legislative Affairs, by phone

[4] Daniel H, Snyder Sulmasy L. "Policy Recommendations to Guide the Use of Telemedicine in Primary Care Settings." American College of Physicians, November 17, 2015: https://www.acpjournals.org/doi/full/10.7326/M15-0498

at (202) 261-4526 or via email at jfrost@acponline.org with any further questions or if you need additional information.