



American College of Physicians Statement for the Record United States Senate Finance Committee Hearing

COVID-19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned May 19, 2021

The American College of Physicians (ACP) is pleased to submit this statement for the record concerning the Senate Finance Committee’s recent hearing on “COVID-19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned. We would like to thank Chairman Wyden and Ranking Member Crapo for convening this bipartisan hearing to examine how our country and our health care system responded to the challenges posed by COVID-19. This public health emergency (PHE) has shown the value of the expanded use of telehealth that our physicians used when it was no longer safe for them to see many of their patients in their office or clinic as well as additional reforms that should be implemented in Medicare to ensure that our physicians on the frontlines of this pandemic have the tools and resources they need to deliver high quality care to their patients. This statement will provide our recommendations concerning the existing flexibilities and waivers that were granted by the Centers for Medicare and Medicaid Services (CMS) during the COVID-19 pandemic that should be extended after the PHE as well as reforms to Medicare physician payment that should be enacted to improve the value of primary and comprehensive care.

ACP 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.

Summary of ACP Recommendations to Expand Telehealth and Improve Medicare Payment Policy

The following summary provides a list of recommendations concerning the existing PHE telehealth flexibilities issued by CMS during the COVID-19 pandemic that should remain in place after the PHE as well as legislation that should be enacted to expand the use of telehealth and improve Medicare physician payment policy to support primary and comprehensive care.

- **Ensure Medicare payment for audio only telehealth services**
- **Extend CMS flexibility to reduce or waive cost sharing for telehealth services**
- **Continue modifications by CMS to allow flexibilities in direct supervision at teaching hospitals**
- **Extend CMS revised policies to expand remote patient monitoring services**

- Ensure CMS makes coding and payment available for COVID-19 vaccine counseling services
- Enact the Connect for Health Act (S. 1512, H.R. 2903) to remove geographic restrictions on the use of telehealth services
- Enact the Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act (S.168, H.R. 708) to provide temporary licensing reciprocity for telehealth and interstate health services
- Continue to fund the 3.75 percent increase to all physician services that was approved at the end of last year to prevent CY 2022 “budget neutrality” cuts for physician services, including primary care visits and other evaluation and management services
- Ensure that any legislation that addresses budget neutrality treats all services fairly and equitably
- Approve H.R. 1025, the Kids Access to Primary Care Act of 2021 that would ensure that Medicaid payment rates for primary care services are equal to Medicare rates.
- Approve S. 1833, the Ensuring Access to Primary Care for Women and Children Act that would return Medicaid payments for primary care services to Medicare payment levels for two years
- Introduce and approve legislation to extend the five percent bonus that physicians receive if they meet performance expectations in Advanced APMs that is set to expire at the end of 2022.
- Prevent Scheduled Medicare Cuts Due to Sequestration and PAYGO

TELEHEALTH DURING THE COVID-19 PANDEMIC

According to initial data from 2020, the role of telehealth as a method of health care delivery has taken on greater significance as a result of the COVID-19 pandemic as well as its ability to increase access to care for those who live great distances from their doctor’s office and those unable to leave their homes. In an October 2020 report from the Centers for Disease Control and Prevention (CDC), during the first quarter of that year, the number of telehealth visits increased by 50 percent, compared with the same period in 2019, with a 154 percent increase in visits noted in surveillance week 13 in 2020, compared with the same period in 2019. Data for this analysis were provided to CDC from four large national telehealth providers as part of partner engagement to monitor and improve outcomes during the COVID-19 pandemic.¹ A recent survey of 1,594 physicians and other qualified health care professionals from across the U.S. also revealed that only a small percentage reported not having used telehealth for patient care.²

In addition, a February 2021 study in *Health Affairs* examined data of 16.7 million commercially insured and Medicare Advantage enrollees from January to June 2020 and noted that telemedicine use was lower in communities with higher rates of poverty (31.9 percent versus 27.9 percent for the lowest and highest quartiles of poverty rate, respectively). Across specialties, the use of any telemedicine during

¹ Centers for Disease Control and Prevention, [Trends in the Use of Telehealth During the Emergence of the COVID-19 Pandemic — United States, January–March 2020 \(cdc.gov\)](https://www.cdc.gov/media/releases/2020/s1030-telehealth.html), October 30, 2020

² COVID-19 Healthcare Coalition, [Telehealth Impact - Physician Survey Analysis \(c19hcc.org\)](https://www.c19hcc.org/telehealth-impact-physician-survey-analysis), November 16, 2020

the pandemic ranged from 68 percent (endocrinology), to 35 percent (primary care), to 9 percent (ophthalmology).³

As noted in another recent study, health equity in medicine is also a real issue and there are disparities in access to telehealth technology. For those in rural and underserved communities, the nearest clinic may be hours away. Unfortunately, rural communities also suffer from more limited access to broadband internet, which restricted the ability of many in rural communities to access telemedicine pre-pandemic. Additionally, research shows that Black and Hispanic Americans own laptops at lower rates than White Americans, further dividing pre-pandemic access to telemedicine.⁴ Equitable access to broadband internet is critical to the promotion of health equity and quality of care outcomes through telehealth. Congress should provide support for further broadband deployment to reduce geographic and sociodemographic disparities and access to care.⁵

TELEHEALTH AND PRIMARY CARE

ACP 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 this pandemic, internal medicine specialists continue to deliver care to their patients with the expanded utilization of telehealth made possible by new policies enacted by Congress, and implemented by 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 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.⁶ 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

³ Health Affairs, [Variation In Telemedicine Use And Outpatient Care During The COVID-19 Pandemic In The United States | Health Affairs](#), February 1, 2021

⁴ [2020-state-telemedicine-report.pdf \(doxcdn.com\)](#), September 2020, p. 12

⁵ American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics, [ACP, AAFP, and AAP Recommend Post-COVID-19 Telehealth Priorities to Senate HELP Committee \(acponline.org\)](#)

⁶ 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

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. ACP provided a list of our recommendations on the existing PHE telehealth flexibilities that should be continued after the PHE in our [statement](#) to the House Committee on Energy and Commerce March 2, 2021, hearing, "The Future of Telehealth: How Covid-19 is Changing the Delivery of Virtual Care" as well as our [statement](#) for the Health Education Labor Pension (HELP) Committee hearing on "Examining our COVID-19 Response –an Update from the Frontlines" on March 9th of this year. 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 as is, revised or expanded.**

Pay Parity for Audio-Only and Telehealth Services

The College wholeheartedly supports many actions taken by the CMS to provide additional flexibilities for patients and their doctors by providing payment for telephone services. During the PHE, Medicare has covered some audio-only services and will reimburse for both telehealth services and audio-only services as if they were provided in person. 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. These services are instrumental for patients who do not have the requisite broadband/cellular phone networks, or do not feel comfortable using video visit technology. In addition, these changes have greatly aided physicians who have had to make up for lost revenue and while still providing appropriate care to patients. 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.

Evidence shows that patient visits to ambulatory practices have declined significantly and despite a rebound, visits remain 30 percent lower than they were pre-pandemic⁷, with utilization for practice areas such as adult primary care declining by well over 60 percent.⁸ As the need to contain the virus

⁷ Mehrotra, A., Chernew, M., Linetsky, D., Hatch, H., & Cutler, D. (2020, May 19). What Impact Has COVID-19 Had on Outpatient Visits? Retrieved June 03, 2020, from <https://www.commonwealthfund.org/publications/2020/apr/impact-covid-19-outpatient-visits>

⁸ FAIR Health. Healthcare Professionals and the Impact of COVID-19, A Comparative Study of Revenue and Utilization. June 10, 2020.

and maintain appropriate social distancing protocols continues throughout the year, and likely beyond, 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. **ACP believes that existing PHE flexibilities and waivers should be continued, and not be allowed to expire—including payment 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.**

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 reside.**

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 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

<https://s3.amazonaws.com/media2.fairhealth.org/brief/asset/Healthcare%20Professionals%20and%20the%20Impact%20of%20COVID-19%20-%20A%20Comparative%20Study%20of%20Revenue%20and%20Utilization%20-%20A%20FAIR%20Health%20Brief.pdf>

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.**

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.⁹

⁹ 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>

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.¹⁰ 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.

We urge Congress to approve legislation that has been introduced in the 117th Congress, the CONNECT for Health Act (H.R. 2903/S. 1512) that would permanently remove arbitrary geographic restrictions on where a patient must be located in order to utilize telehealth services; enable patients to continue to receive telehealth services in their homes; ensure federally qualified health centers and rural health centers can furnish telehealth services; and establish permanent waiver authority for the Secretary of Health & Human Services during future emergency periods.

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.¹¹ 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.

We also support legislation that has been introduced in the 117th Congress, **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. This legislation would improve the ability of physicians continue to treat patients who move across state lines, which is especially important to maintain care for patients with long established relationships with their primary care physicians.**

Improve Medicare Payment for Primary and Comprehensive Care

This pandemic has shown the value of internal medicine physicians (internists) who remain on the frontlines of diagnosing and treating patients with COVID-19 as well as confronting the challenges of caring for patients who require an extensive amount of time and care management for chronic illnesses such as cancer, heart disease, and diabetes. The financial strain on physician practices has

¹⁰ 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

¹¹ 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>

increased during the pandemic due to lost revenue from lower patient volume as well as the need to purchase personal protective equipment (PPE) and reconfigure their offices to be COVID safe. Yet, they continue to work in a health care system that has historically underinvested in primary and cognitive care. A significant portion of the work of internal medicine physicians is tied to evaluation and management (E/M) services (office-based visits with patients) that have long been undervalued in both Medicare and Medicaid.

Support and Sustain Payments for Evaluation and Management E/M Services

ACP appreciates recent policies enacted by Congress and implemented by CMS to strengthen internal medicine by increasing payment under Medicare for office-based E/M services. CMS issued a final rule in 2020 that provided an increase in payments for physicians' undervalued E/M services, with an additional add-on for complex visits, effective on Jan. 1, 2021. ACP fully [supported](#) the implementation of this increase in payment for E/M services, noting it was long overdue and absolutely essential but only *partially* offsets the huge losses of revenue from the COVID-19 pandemic experienced by internal medicine specialists and other frontline physicians.

Federal law requires that any increases to physician services in the MPFS final rule (such as those applied to E/M services in the 2021 PFS) must be offset by an across-the-board budget neutral (BN) reduction to all services paid under the fee schedule, to keep overall spending budget neutral. The 2021 PFS rule would have imposed a substantial BN adjustment, with physicians providing undervalued E/M services seeing major improvements, while others who do not bill for E/M were facing reductions in payment for other services in Medicare. **ACP was pleased that at the end of last year, Congress passed legislation, H.R. 133, the Consolidated Appropriations Act of 2021, that included a provision providing for a temporary 3.75 percent increase to ALL services which has and will help to mitigate a substantial portion of the cuts that were expected from budget neutrality while further increasing payments to frontline primary and comprehensive care physicians. All physician services will again be subject to reductions due to the application of budget neutrality in the 2022 PFS unless Congress steps in to stop it.**

Any legislation to address budget neutrality should incorporate all physician services, and the specialties providing them, equitably; so that budget neutrality relief does not preferentially prevent BN cuts to non-E/M services while allowing them to go into effect for E/M services. **We urge Congress to continue to fund the 3.75 percent increase to all physician services that was approved at the end of last year to prevent CY 2022 "budget neutrality" cuts for physician services, including primary care visits and other evaluation and management services as well as ensure that any legislation that addresses budget neutrality treats all services fairly and equitably.**

Improve Payment for Primary Care Services under Medicaid

Under Medicaid, on average, a clinician treating a Medicaid enrollee is paid about two-thirds of what Medicare pays for the same services and only half of what is paid by private insurance plans. Primary care clinicians commit themselves to a long-term relationship with all their patients — including Medicaid beneficiaries — and provide not only first-contact and preventive services, but also the long-term care for chronic conditions that minimizes hospital admissions and reduces costs to the system. Medicaid enrollment has increased by more than 8 percent over the past year as a result of pandemic-

related job and income loss, making the demand for primary care and pediatric clinicians in the Medicaid program more acute than ever. At the same time, physician practices have faced financial challenges due to decreased visit volume and increased expenses such as personal protective equipment, technology to provide telehealth and infrastructure to administer COVID-19 tests and vaccines. Physician practices that accept large numbers of Medicaid patients face further challenges. The low payment rate for Medicaid services, compared with that of Medicare or private payers, is exacerbating their financial instability.

Fortunately, legislation has been introduced this year in the House and Senate to elevate payment levels for primary care services in Medicaid equal to Medicare levels. We urge Congress to pass:

- **H.R. 1025, the Kids Access to Primary Care Act of 2021 that would ensure that Medicaid payment rates for primary care services are equal to Medicare rates. The Affordable Care Act (ACA) included a provision that required states to raise Medicaid payment rates for primary care services equal to Medicare rates in 2013 and 2014 but this provision expired after those two years and was not renewed by Congress.**
- **S. 1833, the *Ensuring Access to Primary Care for Women and Children Act* that would return Medicaid payments for primary care services to Medicare payment levels for two years and expand the number of clinicians eligible for this increase to ensure that all Medicaid enrollees have access to the primary and preventive care they need. The legislation also raises Medicaid payment rates to those of Medicare for the duration of any future public health emergency and six months thereafter.**

Extend Incentives for Physicians to Participate in Advanced Alternative Payment Models

This pandemic has highlighted the need for physicians to transition their practice away from the traditional fee for service model to Advanced APMs that promote value-based care and provide rapidly expanded capabilities, such as care management, call centers, remote monitoring and telehealth, to meet the shifting care needs resulting from COVID-19. In addition to any model specific payments, clinicians who participate in Advanced APMs, in a substantial way, can earn a five percent Medicare bonus (set to expire at the end of next year) if they meet certain thresholds of patients or payment through their work in this model. ACP is concerned that if physicians are not assured that this five percent bonus will be available after next year, they will be less inclined to invest in the necessary infrastructure transformation in their practices to deliver care in an Advanced APM. We urge members of the Senate Finance Committee to **introduce and approve legislation to extend the five percent bonus that physicians receive if they meet performance expectations in Advanced APMs that is set to expire at the end of 2022.**

Prevent Scheduled Medicare Cuts Due to Sequestration and PAYGO

We applaud the passage of H.R. 1868 that was signed into law earlier this year, which delayed the implementation of a two percent Medicare cut to physicians scheduled on April 1st of this year that would have been triggered by a process known as sequestration, which is designed to reduce federal spending. We remain concerned that H.R. 1868 only delayed the two percent Medicare sequestration

cut to physicians until January 1, 2022 and unless Congress acts before the end of this calendar year – this cut will be implemented. H.R. 1868 also failed to waive additional Medicare cuts that would be imposed on physicians through a federal law known as PAYGO – that would reduce Medicare payments to physicians up to 4 percent at the end of this year. **As internal medicine physicians continue to struggle with the financial challenges imposed by the COVID-19 pandemic, these Medicare cuts would deal a devastating blow to their ability to deliver high quality care to their patients and we urge Congress to act before the end of CY 2021 to prevent scheduled cuts for physician services, including primary care, resulting from budget sequestration and PAYGO budget rules.**

Conclusion

We appreciate the opportunity to provide our recommendations to the Senate Finance Committee concerning the lessons learned from the COVID-19 pandemic including the health reforms that should remain in place at CMS after the PHE has ended. We look forward to working with members of this committee to enact the bills noted in this statement that have already been introduced in the 117th Congress as well as policies that should be introduced in legislation and passed in this Congress to expand the role of telehealth and reform Medicare payment policies to sustain and improve the value of primary and comprehensive care. Should you have any questions regarding this statement, please do not hesitate to contact Brian Buckley, Senior Associate for Legislative Affairs, at bbuckley@acponline.org.