



Sound Policy. Quality Care.

April 17, 2020

The Honorable Mitch McConnell
Senate Majority Leader
United States Senate
Washington, DC 20510

The Honorable Charles Schumer
Senate Minority Leader
United States Senate
Washington, DC 20510

The Honorable Nancy Pelosi
Speaker of the House
U.S. House of Representatives
Washington, DC 20515

The Honorable Kevin McCarthy
House Minority Leader
U.S. House of Representatives
Washington, DC 20515

The Honorable Steny Hoyer
House Majority Leader
U.S. House of Representatives
Washington, DC 20510

RE: Fourth COVID-19 Response Package

Dear Leader McConnell, Leader Schumer, Speaker Pelosi, Leader Hoyer, and Leader McCarthy:

Thank you for your leadership and your tireless, around-the-clock efforts during this unprecedented crisis. The Alliance of Specialty Medicine (the "Alliance") represents more than 100,000 specialty physicians, and is dedicated to the development of sound federal health care policy that fosters patient access to the highest quality specialty care. We urge you to address the following issues as Congress works to assemble its next legislative response to the COVID-19 pandemic.

- **Ensure Initial Disbursements From the \$100 Billion Fund Can Be Retained By Providers Who Have Delayed Elective Procedures** – Congress and the Administration should provide clearer guidance regarding the potential to retain the initial tranche of funds to offset lost revenue.
- **Revise the Terms of the Medicare Accelerated and Advance Payment Program** – Congress should reduce the interest rate, extend the repayment timeline, set a percentage cap on the amount CMS is allowed to keep as repayment, and delay the implementation of the repayment period until 120 days after the public health emergency (PHE) expiration.
- **Provide Additional Medical Liability Protections for Physicians During COVID-19 Response** – Congress should provide physicians immunity from civil liability for any injury or death alleged to have been sustained because of any acts or omissions undertaken in good faith while responding to the COVID-19 pandemic, and ensure that liability is limited for physicians practicing outside their specialty area as necessary to fight coronavirus.

- **Waive Medicare Physician Fee Schedule Budget Neutrality Requirements and Provide Positive Physician Payment Updates** – Congress should suspend budget neutrality requirements for the Medicare Physician Fee Schedule (MPFS) for no less than five years to ensure that changes in underlying payment policies do not counteract the other steps Congress and the Administration are making to protect our health care system and patient access to care, both during the PHE and during our recovery from the PHE. In addition, it is important now more than ever that CMS should strive to maintain the integrity of the statutorily mandated resource-based relative value system (RVS) by ensuring that codes that have values derivative of the office and outpatient E/M codes are updated commensurately, including codes with global periods. We, therefore, urge Congress to mandate CMS include the updated E/M values in codes with global periods. Further, Congress should provide positive physician payment updates to Medicare physicians during CY 2020 – CY 2025, replacing the zero percent annual updates required by the Medicare Access and CHIP Reauthorization Act (MACRA).
- **Further Clarify Eligibility for the Paycheck Protection Program** – Congress should expand eligibility to include 501(c)(6) nonprofits as well as business concerns with no more than 500 employees per physical location and with a North American Industry Classification System code beginning with 62, which covers employers in the “Health Care and Social Assistance” sector.
- **Address Physician Workforce Shortages** – Congress should adopt legislation such as the Resident Physician Shortage Reduction Act (H.R. 1763/S. 348) and H.R. 5924 to address the physician workforce shortages that jeopardize access to care and will only be amplified by the COVID-19 crisis.

More details on these priorities can be found in the accompanying document.

Thank you again for your leadership and for continuing to work to address this ongoing crisis. Please do not hesitate to contact any of the undersigned organizations should you have questions or require additional information.

Sincerely,

American Academy of Facial Plastic & Reconstructive Surgery
 American Association of Neurological Surgeons
 American College of Osteopathic Surgeons
 American College of Mohs Surgery
 American Gastroenterological Association
 American Society for Dermatologic Surgery Association
 American Society of Cataract and Refractive Surgery
 American Society of Echocardiography
 American Society of Plastic Surgeons
 American Society of Retina Specialists
 American Urological Association
 Coalition of State Rheumatology Organizations
 Congress of Neurological Surgeons
 National Association of Spine Specialists

Alliance of Specialty Medicine Fourth COVID-19 Response Package

Ensure Initial Disbursements From the \$100 Billion Fund Can Be Retained By Providers Who Have Delayed Procedures –

We appreciate the swift action of the Centers for Medicare and Medicaid Services (CMS) in quickly establishing an efficient process by which providers can receive part of the initial tranche of \$30 billion. By providing those funds without an application and merely relying upon a percentage of the 2019 Medicare fee-for-service (FFS) claims, many providers received the grant funding (not loans) as early as Friday, April 10. Unfortunately, we are concerned that the terms and conditions may unnecessarily preclude some providers from being able to make the formal attestation and retain those funds.

Unlike the descriptor of the program which notes that the initial funding is to assist “those providers who are struggling to keep their doors open due to healthy patients delaying care and cancelled elective services,” the terms and conditions indicate that provider must attest that the provider “currently provides diagnoses, testing, or care for individuals with possible or actual cases of COVID-19.” Whether or not physicians have *directly* cared for COVID-19 patients, physicians have nevertheless significantly changed their practices as a result of the pandemic. We therefore, remain concerned that some providers who have not been able to see any patients could not attest to this situation -- despite the fact that they have had significant revenue reductions and despite the fact that the terms and conditions also state that they have had significant revenue reductions because of COVID-19. While the terms and conditions state that the payment will be used for “lost revenues that are attributable to coronavirus,” we nevertheless believe additional clarification is necessary.

Providers have 30 days from receipt of the payment to attest to the terms and conditions (or contact HHS and remit the full amount as instructed, so ***we urge Congress and the Administration to provide more precise guidance to specify that the initial funding is broadly available to offset lost revenue as a result of COVID-19.***

Revise the Terms of the Medicare Accelerated and Advance Payment Program –

We appreciate the Administration’s effort to increase cash flow to physician practices via the Medicare Accelerated and Advance Payment Program. However, the ability of physician practices to feasibly rely on this loan program with a payback mechanism based on future claims submission is complicated by several factors:

- An exorbitant interest rate on unpaid balances;
- Future cash flow interruptions that could be created by the terms of the program; and
- The lack of clarity about the volume of physician services.

For physician practices, the program allows practices to request a payment advance (for three months of services) that will be repaid via claims for furnished services provided in the future. These repayments come from claims submitted 120 days later and repayment continues through day 210. This means that physician repayment for what would be an estimate of three months’ worth of claims during non-public health emergency (PHE) circumstances would be collected via claims submissions during a three month period when we are unsure that anything will have returned to “normal.” Any balances at the end of the three-month repayment period are subject to a 10.25% interest rate as set by the Secretary of Treasury according to the statute. Given the repayment timeline and that lack of clarity about volume levels in the near term, ***the Alliance urges Congress to make several critical changes to the Medicare Accelerated and Advance Payment Program:***

1. **Reduce the interest rate** to which balances are subject;

2. **Extend the repayment timeline** so that the period of repayment is longer than the period for which practices can request advance payment (e.g., one year to repay a 60-month request of funding as the hospitals have received);
3. **Set a percentage cap on the amount CMS is allowed to keep as a repayment** from future submitted claims to ensure that the repayment process does not create another Medicare revenue cash flow problem in the future; and
4. **Delay the implementation of the repayment period until 120 days after the PHE expiration** (rather than 120 days after receipt of payment) so that there is a more reasonable expectation that repayment obligations do not activate until we are in an environment where claims submission might actually be able to contribute toward the balance due.

Provide Additional Medical Liability Protections for Physicians – We are grateful that the Coronavirus Aid, Relief, and Economic Security (CARES) Act incorporated important protections for volunteer physicians during the COVID-19 crisis. However, concerns remain related to potential medical liability. ***The Alliance urges Congress to provide physicians immunity from civil liability for any injury or death alleged to have been sustained because of any acts or omissions undertaken in good faith while responding to the COVID-19 pandemic.*** Such legislation should maintain vital protections for those who are victims of acts of gross negligence or willful misconduct. Additionally, many physicians are working on the front lines to address the surge in COVID-19 cases, including in service to assist emergency care, testing and treatment. Therefore, ***the Alliance urges Congress to ensure that liability is limited for physicians who come out of retirement and for physicians practicing outside their specialty area as necessary to fight coronavirus*** during this unprecedented time.

Waive Medicare Physician Fee Schedule Budget Neutrality Requirements and Provide Positive Physician Payment Updates – In the calendar year 2020 Medicare Physician Fee Schedule (MPFS) Final Rule, CMS instituted several policies regarding documentation and payment for office and outpatient evaluation and management (E/M) services. These finalized policies are estimated to have a dramatic redistribution effect on the overall MPFS which, for many specialties, is expected to generate dramatic cuts. For some, these cuts will stretch well beyond 10%. While we do not yet know how long the PHE will last, we do know with certainty that our national recovery will stretch throughout next year, assuming we are still not in the middle of a PHE. ***The Alliance urges Congress to suspend budget neutrality requirements for the Medicare Physician Fee Schedule for at least the next five years to ensure that changes in underlying MPFS policies do not counteract all of the other steps Congress and the Administration are making to protect our health care system and patient access to care, both during the PHE and during our recovery from the PHE.*** While the first payments affected by the CY 2021 policies might not be seen until claims submissions that begin on January 1, 2021, every practice is aware that they are coming. These cuts will be an added pressure on practices that are already struggling. We urge Congress to remove this cloud over physician practices by waiving the statutory budget neutrality requirements that are generating these 2021 and future cuts. This will help practices *now* by mitigating the risk of future payment reductions as we survive and look to emerge from this crisis. In a related matter, we are deeply concerned with the budgetary impacts of the CMS-finalized modifications for coding and payments for E/M services for CY 2021. Our concerns extend to CMS' failure to apply the newly revised E/M values to global codes, which was recommended by the American Medical Association (AMA) Relative Value System Update Committee (RUC) and virtually all medical specialties.

We are concerned about the precedent CMS is setting by “delinking” E/M values from the E/M services delivered as part of global codes, while maintaining the link between E/M values and other PFS services. We continue to believe it is grossly inappropriate for the agency to “pick and choose” when to apply established E/M values in the valuation of other services that incorporate E/M visits, or in this case, based on the context in which E/M

services are delivered. Now more than ever, we believe that CMS should strive to maintain the integrity of the statutorily mandated resource-based relative value system (RVS) by ensuring that codes that have values derivative of the office and outpatient E/M codes are updated commensurately, including codes with global periods. We, therefore, urge Congress mandate that CMS reverse its decision to exclude the updated E/M values in codes with global periods.

Furthermore, as a result of MACRA, Medicare physicians did not receive a positive payment update this year, nor will they receive a positive payment update for the next five years (i.e., through CY 2025). Like other sectors of healthcare, physicians continue to face increasing practices costs due to inflation. And, given the current pandemic, the financial strain on practices is even more pronounced. To help stabilize the current Medicare physician workforce, Congress should replace the “null” updates required by MACRA with positive payment updates for the period beginning with CY 2020 – CY 2025.

Further Clarify Eligibility for the Paycheck Protection Program – On behalf of our physician members, thank you for establishing the Paycheck Protection Program (PPP), which will help many physician practices stay afloat during this unprecedented time. Access to this program for those who qualify will not only protect the jobs in those practices, which is the PPP’s primary intent, but it will also ensure that medical practices are in a position where they can meet the immense pent-up need for medical care once the COVID pandemic is behind us.

As you monitor the rollout of this new program and identify potential amendments to it, we hope that you will consider the following two opportunities for improvement to maximize the program’s effectiveness for physician practices and societies.

First, the CARES Act limits eligibility for the PPP to only certain nonprofits. Specifically, the law states that qualifying tax-exempt nonprofit organizations described in section 501(c)(3) of the Internal Revenue Code qualify for the PPP. Nonprofit groups organized under section 501(c)(6) are not included, which means these nonprofits are not eligible for these vital funds. Many medical societies, which are both small businesses and employers, are both (c)(3)s and (c)(6)s. These societies have incurred and will continue to incur significant financial losses due to the cancellation of annual meetings and conferences, which represent a large percentage of their annual revenues – for some, more than half. Similar to other industries, insurance coverage for lost revenues has been available for a fortunate few, but this coverage is spotty and may not be available at all in some cases.

Medical societies are a trusted and effective forum for physicians to, among other things:

- Exchange groundbreaking and timely scientific and medical information;
- Share best practices on how to safely deliver care during this trying time; and
- Access pertinent analyses and summaries of new, critical information released by HHS on an almost daily basis.

Our physicians are relying on their societies to help navigate the COVID-19 pandemic. Yet, the stark reality is that some of those societies may not survive without access to the PPP or other similar programs. Already, some medical societies have had to make devastating staff reductions, which is precisely what the PPP is intended to prevent. Thus, ***the Alliance strongly urges you to expand PPP eligibility to include 501(c)(6) nonprofit organizations as well.***

Second, the CARES Act limits eligibility to employers with less than 500 employees, and it includes special “affiliation rules” which may require counting employees from numerous care sites. For some specialties,

however, it is not unusual to have large, national practices with several locations, which may add up to more than 500 employees. In fact, in an informal poll, one of our member societies found that 40% of its responding practices would not qualify for the PPP due to the 500-employee threshold.

During these times, having a larger employee pool does not protect an employer in the service industry from the devastating effects of drops in revenue. Congress recognized this when it specifically qualified employers in the hotel and restaurant industry for participation in the PPP, even if they employ more than 500 people – as long as they do not employ more than 500 people *per location*.¹ National physicians' practices providing medical services are similarly situated. Given the unique impact of this crisis is having on the medical profession – particularly the impact on specialty practices due to the indefinite suspension of all non-essential surgeries and other medical procedures – ***the Alliance urges you to provide a similar provision for medical service providers. This could be accomplished by adding eligibility for business concerns with no more than 500 employees per physical location and with a North American Industry Classification System code beginning with 62, which covers employers in the “Health Care and Social Assistance” sector.*** We urge you to include this language, or similar language to that effect, in any amendments to the existing PPP.

Address Physician Workforce Shortages – According to an April 2019 report by the Association of American Medical Colleges (AAMC), the United States will face an overall shortage of between 46,900-121,900 physicians by 2032. Specialty shortages will be particularly large– 24,800-65,800 for specialists and 14,300-23,400 for surgeons. ***The Alliance urges Congress to adopt legislation to address these physician workforce shortages that jeopardize access to care and will only be amplified by the COVID-19 crisis.*** Specifically, the bipartisan Resident Physician Shortage Reduction Act (H.R. 1763/S. 348) will help preserve access to specialty care by:

- Increasing Medicare-supported graduate medical education (GME) residency slots by 15,000 over the next five years;
- Directing half of the newly available positions to training in shortage specialties;
- Specifying priorities for distributing new slots; and
- Studying strategies to increase the diversity of the health professional workforce.

In addition, H.R. 5924 is a bipartisan measure that would improve access to care in rural America through a student loan forgiveness program for specialty physicians. Specifically, the bill would allow a portion of their eligible student loans (up to \$250,000) repaid by the federal government in exchange for practicing in a rural community for six years.

The current workforce shortage will be exacerbated by the lasting impact of the current pandemic due to the loss of physicians, burnout, and retirement. These bills would help address the critical shortage of physicians and ensure our healthcare system is prepared for the future.

¹ CARES Act section 1102 provides that, “any business concern that employs not more than 500 employees per physical location of the business concern and that is assigned a North American Industry Classification System code beginning with 72 at the time of disbursement shall be eligible to receive a covered loan.” NAICS codes beginning with 72 cover employers in the “Accommodation and Food Services” sector.