AMA
AMERICAN MEDICAL ASSOCIATION

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Matt Eyles
President & CEO
America's Health Insurance Plans
601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, DC 20004

Dear Mr. Eyles:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to urge America's Health Insurance Plans (AHIP) and its members to take immediate measures to reduce administrative burdens for physicians and practice staff during the current COVID-19 (2019 novel coronavirus) public health emergency. The COVID-19 pandemic is placing unprecedented strain on our nation's health care system. Our physicians on the frontline of this crisis face overwhelming challenges, including surging numbers of acutely ill patients, insufficient testing supplies, limited inpatient beds, and inadequate personal protective equipment—all while risking their own personal health and safety. Under these dire circumstances, it is imperative that health plans suspend program requirements that interfere with or distract from physicians' ability to focus on patient care.

We appreciate the AHIP Board of Directors' statement last month supporting removal of cost and administrative barriers to COVID-19 testing and treatment and encouraging use of telehealth. We also recognize that many of your members have adjusted their policies in response to the crisis to ensure care access and reduce practice burdens. However, we must stress that the numerous, well-meaning policy modifications across health plans, as well as the rapidity of announcements regarding these changes, are virtually impossible for physicians and practice staff to track during this public health emergency. **Accordingly, we strongly encourage AHIP to leverage its leadership role to increase uniformity across health plans in policy and coverage changes related to the pandemic, with an initial focus on the following high-priority issues that are challenging physicians during this critical time.**

Telehealth
The AMA recognizes the improvements in payment policies and coverage for telehealth services made by many of your members during this public health emergency. Many health plans have adjusted their policies to allow physicians to continue to provide care to their patients via telehealth, whether related to COVID-19 or other medical and/or behavioral health conditions. While these improvements are deeply appreciated and critically important in reducing viral spread, physicians are struggling to manage the multitude of well-intended coverage and payment policy changes. **We urge the payer community to align telehealth coverage, payment policies, and coding rules across plans to avoid diverting scarce physician and staff time to the tracking of different organizations' telehealth programs. In particular, we emphasize the need for policy standardization in the following critical areas:**

- Allowing telehealth for new and established patients;
- Suspending limitations on telehealth, including types of services that can be provided via telehealth (e.g., limits on mental health services), originating sites, geographic regions, or network status;
- Temporarily allowing coverage and payment for all telehealth modalities, including audio-only;
- Supporting payment parity between telehealth and in-person visits, including equal payment for audio-only and audiovisual technology;
- Ensuring broad coverage and payment for telehealth services across all lines of business, including Medicaid; fully insured; self-insured; association; and short-term, limited duration insurance plans;
- Providing coverage and payment of COVID-19-related telehealth services with no patient cost-sharing (i.e., co-payments, co-insurance, deductibles);
- Suspending annual limits imposed on telehealth services;
- Ensuring that patients have access to telehealth from the in-network physician(s) who typically provide their in-person care, without requiring the physician(s) to contract with a specific telehealth service; and
- Implementing telehealth coding and modifier usage consistent with Centers for Medicare & Medicaid Service (CMS) rules (e.g., place of service same as in-person visit, with modifier 95 appended to claims).

The AMA continues to offer physicians coding advice, including a guidance document describing various coding scenarios for in-person and telehealth services provided during this crisis.[1] We encourage you to share this document with your members to support coding consistency across plans.

Prior authorization (PA)
Under normal circumstances, health plans' PA requirements frequently delay access to medically necessary care, negatively impact patient clinical outcomes, and drain practice resources, as illustrated by the results of the 2018 AMA Prior Authorization Physician Survey.[2] The AMA has continued to advocate that PA be "right-sized" to protect patients from clinical harm and reduce practices' administrative hassles. **However, under the current exceptional situation brought on by the COVID-19 crisis, we urge health plans to temporarily suspend all PA requirements for new medical services (including procedures, admissions to acute and nonacute care settings, and durable medical equipment) and prescription drugs and extend existing PA approvals.**

We realize that many health plans are waiving PA requirements for COVID-19-related testing and treatment, and some are also now temporarily lifting PA requirements for patient transfers to nonacute care settings. While these allowances are appreciated, they are insufficient to address the magnitude of the current crisis. Moreover, tracking swiftly changing, highly varied PA policies across health plans is extremely challenging during this health emergency. At a time when medical practices are overwhelmed trying to respond to the needs of both patients acutely ill with COVID-19 and those requiring routine treatment for chronic conditions—all while facing the additional challenge of maintaining social distance to prevent viral transmission—it is disappointing that health plans are maintaining PA requirements that

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[1] American Medical Association. Special coding advice during COVID-19 public health emergency. Available at: https://www.ama-assn.org/system/files/2020-04/covid-19-coding-advice.pdf. Accessed April 13, 2020.
[2] 2018 AMA Prior Authorization Physician Survey. Available at: https://www.ama-assn.org/system/files/2019-02/prior-auth-2018.pdf. Accessed April 13, 2020.

divert physician and staff time away from direct care, force patients to make multiple trips to the pharmacy, and delay hospital discharges. PA requirements also burden those practices that have been forced to limit the number of staff onsite and/or hours of operation. **We urge you to call on your members to institute a temporary global PA waiver across all medical services and prescription drugs during the public health emergency to protect timely access to treatment for all patients—not just those with COVID-19—and ensure that valuable physician time is reserved for saving lives and easing care delivery for patients, not fulfilling administrative requirements.**

Medicare Advantage (MA) and other audits/record requests

MA plans routinely demand medical records from physician practices and fulfilling these documentation requests is time-consuming and costly. While MA plans may request medical records from practices to comply with CMS' risk adjustment data validation (RADV) audits, only a small fraction of MA plans' audits are linked to the CMS RADV process. Rather, many of these burdensome audits are used by MA plans to support increases in their enrollees' risk scores.

On March 30, 2020, CMS suspended RADV-related activities and directed MA organizations to stop soliciting RADV-related medical records from providers. CMS also adopted several changes to the 2021 Star Ratings to address the disruption to data collection and plan performance in 2020 posed by the COVID-19 pandemic. However, the AMA has received multiple physician complaints about MA plans continuing their own risk adjustment audits and data collection requests. During the COVID-19 emergency period, overwhelmed physician practices cannot comply with these onerous record requests related to MA plan risk adjustment scores or other audits. This is particularly true for practices that have temporarily reduced working hours for their support staff. **Accordingly, the AMA requests that AHIP urge its members to suspend any audit activities and data requests during the COVID-19 emergency, including those initiated by MA plans to increase members' risk adjustment scores or Star Ratings.**

Attestations related to credentialing and provider directories

Health plans routinely require practices to attest to the veracity of data related to physician credentialing and provider directories. The cumulative workload of responding to these numerous and uncoordinated requests across many different health plans significantly burdens physicians and their staff under typical practice circumstances. During the COVID-19 pandemic, responding to credentialing and directory attestation queries is simply infeasible. **To eliminate this administrative burden during the current public health crisis, we urge AHIP to call on its members to temporarily suspend all new credentialing and provider directory attestation requests. Additionally, health plans should extend the deadline for responses to existing attestation requests until after the public emergency period**. These provisions are necessary to ensure that physicians remain credentialed and maintain their network status during the COVID-19 crisis which will, in turn, protect patients' access to care.

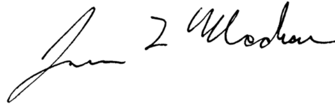
Timely filing requirements

Given the unprecedented demands being placed on physician practices, health plans should suspend any timely filing requirements for claims and any other transactions or correspondence. Many physicians and practice staff are consumed with the urgent needs of their patients during this emergency period, and routine administrative and revenue cycle tasks should be minimized to focus on care delivery. Further delays in these routine processes may result from emerging questions regarding coding and billing for COVID-19 treatment and telehealth scenarios. The previously mentioned lack of standardization across plans in coding requirements exacerbates the confusion practices face in this realm. Additionally, many practices have been forced to furlough staff who typically complete coding, billing, and other

administrative duties. **For all of these reasons, we request that AHIP encourage its members to immediately extend all deadlines for filing of claims and related communications, to include initial claim submission, additional documentation needed to support claim adjudication, grievances and appeals, and utilization management programs.** This leniency will be vital to ensuring the financial viability of practices after the initial crisis has passed.

While we all will face many uncertainties and challenges in the coming months, I am confident that our organizations can work together to protect patients' access to treatment, free clinicians to focus on patient care, and reduce administrative burdens that represent needless waste for both physician and health plans during the COVID-19 pandemic. We urge AHIP to lead its members in swiftly and uniformly implementing the policy changes outlined above. If you would like to further discuss any of these recommendations, please contact Robert D. Otten, Vice President, Health Policy, at rob.otten@ama-assn.org.

Sincerely,



James L. Madara, MD