
Overview
The COVID-19 pandemic has wreaked havoc on the entire health care system, and has been particularly financially devastating to small, independent physician practices. A recent study published in *Health Affairs* projects that primary care practices will lose an average of $67,774 in gross revenue per full-time physician over the course of 2020. Such financial losses severely threaten the financial viability of small and independent physician practices, many of which only have a few months’ financial reserves to cover salaries and other practice expenses.

Congress has responded to the crisis by passing a series of legislative stimulus packages that include, among several provisions, measures to provide financial relief for health care providers to help offset financial losses caused by the pandemic. Unfortunately, the distribution of these funds has been uneven and plagued by constantly changing and inconsistent guidance that has been confusing for physicians. Notwithstanding these measures, physician practices continue to suffer devastating financial losses that threaten their viability.

HHS has also implemented several regulatory flexibilities to support increased use of telemedicine during this public health emergency (PHE). While these flexibilities have remained a vital component of the U.S. health care system’s response to COVID-19, small and independent physician practices have had much more difficulty ramping up their telemedicine systems and workflows to treat their patients and keep their practices financially afloat.

As Congress considers another stimulus package, and HHS and other agencies refine their approach to distributing funding, PAI urges consideration of the following policy priorities:

- Continue financial support in the form of additional relief funds for all physician practices and adjust the distribution methodology to ensure equitable payments to all physician practices, including those with high Medicare Advantage and dual-eligible patient mixes as well as Medicaid-focused practices (e.g., pediatrics/pediatricians and some OBGYNs).

- Address the Provider Relief Fund distribution formula that resulted in inequitable relief funding, with highest payments made to hospitals with the highest share of private health insurance revenue, further exacerbating the existing inequities and undermining barriers to care for the nation’s most vulnerable patients.

- Amend federal law to clarify that financial assistance through the Provider Relief Fund is not taxable, and that entities receiving these funds can maintain tax deductions attributable to these funds.
- Continue current flexibilities for telehealth, remote patient monitoring (RPM), and communication technology-based services (CTBS), as well as continue increased reimbursement for telehealth services (including audio-only telehealth services) in Medicare, to ensure continued access to necessary physician services.

- Expand funding opportunities that enable physicians to improve telehealth/virtual platforms, operational capacities, and data and interoperability capacities.

- Continue and improve financial supports through the Paycheck Protection Program (PPP) and through necessary business insurance protections to cover salaries and overhead expenses as pandemic-related losses continue and are expected to continue post-PHE.

- Establish a multi-stakeholder task force to develop a National Roadmap to inform health care policies for this and future public health emergency.

**Relief Funding Concerns and Considerations for Physicians and Physician Practices**

Funding provided to physicians to balance losses incurred during COVID-19 has been vital to the survival of physician practices, especially small and independent physician practices. However, there have been issues related to the distribution formulas, timing, constantly changing guidance and reporting requirements, and seemingly lack of foresight to consider all types of practice types – specifically those with high Medicare Advantage and dual-eligible patient mixes, as well as Medicaid-focused practices (e.g., pediatrics/pediatricians and some OBGYNs).

**Lack of Accounting for Increased Cost of Care for the Most Vulnerable**

Due to government restrictions on “non-essential” health care services and patients’ continued concerns about seeking health care services for fear of infection, as well as increases in existing health and social inequities in minority communities, the most vulnerable populations have seen a noticeable decrease in care frequency. Additionally, essential workers, who may be Medicaid or Dual-Eligible patients, may have greater exposure risk. However, given the nature of their employment and/or other factors, these essential workers have been unable to, or cannot afford to, take leave to seek care. Extensive investments must be made to improve the reach and capacity of physician practices that serve vulnerable populations, as such patient populations will likely present with conditions and health complications that have advanced since beginning isolation due to ongoing lack of monitoring and care delivery.

**PAI Recommendation**

Policymakers should ensure all physicians impacted by a PHE are supported financially with disaster relief funding consistent with their entire practice profile, especially when they are treating some of the most medically vulnerable patient populations. Further, it is important that this is done in a more streamlined and simplified manner than has been employed under the current PHE to-date, so as not to increase administrative burden for physician practices.

Equitable treatment and distribution of relief fund and reimbursement payments is important for those caring for the most vulnerable populations, e.g., Medicaid and Dual-Eligible patients, recognizing that many of these patients could have experienced increased severity of illness during the PHE. Specifically, additional funding, in addition to disaster relief funding and existing telehealth grants, should be provided to improve the virtual capacity and infrastructure of physician practices so they may continue to provide high-touch services to vulnerable patients (including funds to improve the technological capabilities of patients and
caregivers). This could include targeted funding through existing vehicles available through the Healthcare Resources & Services Administration (HRSA), Administration for Community Living (ACL), and/or the Federal Communications Commission (FCC), or through another entity/vehicle entirely. Policymakers should also increase Medicaid physician payments to Medicare parity throughout the PHE and at least two years post-PHE to maintain a stable network of physicians available to treat the most vulnerable populations.

**Decreased Financial Assistance Under the General Distribution’s Methodology**

While the updated guidance on April 24 expanded the Provider Relief Fund assistance for physicians—especially for those for whom a majority of Medicare revenue was through Medicare Advantage—the Relief Fund formula still presents issues. An example of how this methodology currently works is displayed below (as relayed under current FAQ guidance):

- Distribution 1: Physician receives funding from the initial $30 billion tranche equal to 1% of 2018 net patient revenues.
- The physician determines that total incurred losses for March and April equals ~1.9% of 2018 net patient revenues.
- Distribution 2: Physician is only eligible for additional funds equal to .9% of 2018 net patient revenues. The physician does not receive an additional 1% since losses for March and April are less than 2% of total 2018 net revenue.

HHS clarifies that physicians and practices that believe they may have been overpaid should reject the entire General Distribution payment and submit separate revenue documents to facilitate HHS determining their correct payment. The Department clarifies that it does not intend to recoup funds as long as a physician’s lost revenues and increased expenses exceed the amount of relief funding they have received. However, HHS states that it reserves the right to audit recipients in the future and may collect any funding amounts that were made in error or exceed lost revenue or increased expenses.

**PAI Recommendation**

This lack of clarity over the correct relief fund distribution payment amounts, as well as the potential audit and recoupment exposure, limits physicians’ confidence in both applying and accepting Relief Fund assistance. It is also adds to the uncertainty and instability of the current environment for physicians who are trying to effectively manage and deliver care while adapting to new practice models as a result of the COVID-19 PHE, which will continue to have an impact beyond the duration of the PHE.

Additionally, it is important that the same funding opportunity that is extended and remains available to hospitals and health systems is also extended and made available to physician practices. Funding should not be decreased, terminated, or suspended for physician practices while it continues to be increased or offered to hospitals and health systems. There must be equitable treatment of all providers and provider types who are caring for patients, and hospitals and health systems should not be disproportionately favored over physician practices.\(^1\)

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\(^1\) According to a Kaiser Family Foundation study, “hospitals with the highest share of private insurance revenue received a disproportionately high share of total funds . . . . this analysis demonstrates that the formula used to distribute funding has significant consequences for how funding is allocated among providers.” See, [https://www.kff.org/coronavirus-covid-19/issue-brief/distribution-of-cares-act-funding-among-hospitals/](https://www.kff.org/coronavirus-covid-19/issue-brief/distribution-of-cares-act-funding-among-hospitals/)
**Exclusivity of the General Distribution Decreases Assistance for Physicians with a Diverse Payer Mix**

Many physicians rely on a diverse payer mix of both Medicare fee-for-service (FFS), Medicare Advantage, Medicaid, and other payers. As noted by many physician organizations and federal policymakers, due to the low threshold for General Distribution eligibility and its foundational focus on FFS Medicare, as well as the mutual exclusivity of the General Distribution from other distributions (i.e., Medicaid/CHIP), many physicians who rely on a diverse payer mix are experiencing significant revenue losses compared to other practices (who are more reliant on Medicare FFS).

**PAI Recommendation**

All physicians impacted by a PHE must be supported financially with disaster relief funding consistent with their entire practice profile, especially when they are treating some of the most medically vulnerable patient populations.

**Provider Relief Fund Formula Inadequacies**

Provider Relief Fund formulas do not encompass expenses/revenues associated with drugs and related expenses (i.e., acquisition, maintenance, loss, etc.). As a result, specialties with historically lower cost services, but higher drug and drug-related costs (e.g., oncologists, rheumatologists, endocrinologists, etc.) are severely overlooked by current formulas.

**PAI Recommendation**

There needs to be greater consideration of and relief for all costs for patient care, including drugs, supplies, durable medical equipment (DME), etc.

**Significant Tax Exposure for Relief Fund Recipients**

Per recent guidance by the Internal Revenue Service (IRS), for-profit healthcare providers must pay taxes on any payments received from the Provider Relief Fund. This decision markedly opposes assumptions among the physician community that such relief funds would be tax exempt, considering that grant funds are generally not taxable and especially considering the drastic financial impacts of COVID-19 realized across the U.S. health care system. However, notably, the CARES Act does not explicitly extend tax exemption protections to payments from the Provider Relief Fund, despite such protections being outlined for other CARES Act supports, such as Paycheck Protection Program (PPP) forgivable loan expenses.

**PAI Recommendation**

Many physician practices are now going to face considerably larger financially hardships through state and federal tax liabilities tied to relief fund receipts. Policymakers must consider amending current guidance and/or statutory language and clarify that assistance through the Provider Relief Fund is not taxable, and that entities receiving these funds maintain tax deductions attributable to these funds.

**Reporting Requirements and Concerns Relief Fund Recipients**

On July 20, HHHS released a Post-Payment Notice of Reporting Requirements indicating that the Department will require all Provider Relief Fund recipients (including both General Distribution and Targeted Distribution recipients) who received one or more payments exceeding $10,000 in the aggregate to report how such funds were utilized and to demonstrate compliance with the Terms & Conditions of the Provider Relief Fund. Notably, the announcement does not state if recipients who receive less than $10,000 will also be subject to specific reporting requirements. This has been part of an ongoing frustration with the constantly changing guidance and reporting requirements, adding to the complexity and administrative burden tied to the Provider Relief Funds.
**PAI Recommendation**
The everchanging regulations and requirements governing the Provider Relief Fund have caused significant stress and uncertainty within the physician community. Instilling new and potentially burdensome reporting requirements (especially after-the-fact and/or at short notice) presents another critical challenge that physician practices will have to consider when using relief funds. It is critical that policymakers ensure that any future reporting requirements mandated by the Department remain feasible to perform, and remain consistent, so that physicians are not overly burdened with administrative deliverables while trying to serve patients on the front lines of the COVID-19 pandemic.

**Inequitable Benefits for Hospitals with the Highest Share of Private Insurance Revenue**
In May, the Kaiser Family Foundation performed an analysis showing that hospitals with the highest share of private insurance revenue received more than double the relief funding received, per hospital bed, than hospitals with the lowest shares of private insurance revenue ($44,321.00 versus $20,710.00, respectively). This is due, simply, because of the higher revenues reported in previous years (and, therefore, matched in relief funding) among systems with higher private payer mixes and higher margins, than those with predominantly public payer mixes. These trends have continued within the latest $10 billion released in targeted distributions for High-Impact hospitals—with some high-margin hospitals receiving millions more than competing safety net hospitals threatened by insolvency.

**PAI Recommendation**
This discrepancy in relief funding, in favor of high-margin hospitals, only challenges the financial viability of competing health care providers serving our nations safety net, especially independent and small physician practices. Furthermore, such financial challenges potentiate spillover effects that exacerbate health care access barriers and inequities experienced among the most vulnerable populations. Again, additional funding efforts must be distributed to improve the financial viability of safety net physicians and other providers serving our most vulnerable and underserved communities.

**Improve Financial Supports Through the Paycheck Protection Program (PPP), Advanced and Accelerated Payment Programs (APPs), and Business Insurance Protections**
The Paycheck Protection Program (PPP) has continued to provide vital financial supports to physician practices and their respective staff during the COVID-19 pandemic. On June 5, H.R. 7010 – the Paycheck Protection Program Flexibility Act, was signed into law, providing critical flexibilities to the PPP that better support struggling businesses. This included: extending the maturity date of PPP loans; providing more flexibilities in loan forgiveness for non-payroll allowable expenses; and, extending loan deferrment payment periods, among other provisions.

**PAI Recommendation**
We ask policymakers to continue to consider additional flexibilities and improvements to the PPP that further mitigate the financial hardships experienced by physician practices, and that provide enough flexibility in loan forgiveness to adjust for the varying economic impacts and trends associated with COVID-19 experienced among various regions of the U.S. It is vital that physician practices continue to receive

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access to these funds to retain their staff and meet other business expenses necessary for continued provision of care to their patients.

**Plans for APPs for the Ongoing and Future PHEs**

While the recent temporary flexibilities in Medicare’s Advanced and Accelerated Payment Programs (APPs) provided useful financial relief to physician practices, several technical issues experienced with the APPs as well as the withdrawal of the physician portion of the program raise concerns for future PHEs.

**PAI Recommendation**

Policymakers should establish a more streamlined process to trigger advanced payments and/or easily acquire APPs under a PHE declaration. They should also consider a more reduced and fixed interest rate over longer periods of time for recipients who fail to meet the CMS deadline for recoupment (especially for physicians whose revenue was subsequently reduced due to the PHE and are not able to match previous year’s patient volume or revenue as a result of the PHE).

Policymakers must be consistent in offering financial assistance during the PHE to all provider types and specialties, ensuring equitable treatment and consideration of both hospital systems and physician practices. Funding for one should not be later terminated for physicians while still available to hospitals.

Lastly cash-strapped states will not have resources to offer accelerated payments to physicians whose primary business is Medicaid and the Children’s Health Insurance Program. Policymakers should extend relief to these practices absent state-led initiatives to do so.

**Separate Considerations for Business Insurance**

COVID-19 continues to have a profound impact on demand for physician services, with studies finding that practices experienced decreases in patient volume and revenues. Notwithstanding the impact of the PPP and the provider relief fund, this experience has highlighted the need for business insurance for physician practices to ensure that coverage exists or that coverage is not excluded because of a PHE.

As the nation phases back into traditional operations and social policies, the demand and supply for consistent and frequent testing among healthcare personnel/staff must remain high. For physician practices, the financial demands of consistent testing and infection control measures will remain a challenge for the foreseeable future if insurance they have paid for to protect their practice and their employees does not cover these expenses or the associated lost revenue tied to patient care that result from the PHE and/or the response by physicians to the PHE.

If physicians are expected to see, care for, and treat those afflicted by a certain medical condition that is the cause of a PHE, their insurance should cover them for: 1) the loss of revenue associated with this care (and inability to treat other conditions), 2) the additional costs of protecting the public, their employees, and themselves during and immediately after the PHE, and 3) the risk to their employees and themselves of contracting the medical condition.

**PAI Recommendation**

As a result, we encourage policymakers to consider further federal and state financial supports and insurance protections for physician practices to help them meet demands of both patients and employees. There need to be increased options for more affordable business insurance for physician practices. At the
very least, existing insurance policies should cover and not exclude the very reason that there is a PHE and the very nature of a medical practice and physician care delivery during a national crisis.

**Continuing Current Flexibilities and Improving Funding Opportunities to Expand Virtual Services**
Telehealth has remained a vital component of the U.S. health care system response to COVID-19. Due to relaxations in originating site requirements, established relationship requirements, and certain HIPAA requirements, physicians and other health care professionals have been able to maintain, and in certain cases expand, the reach of their medical services to populations in need. Furthermore, CMS has expanded the list of reimbursable telehealth services, as well as the rate of reimbursement for such services, providing consistent and reliable revenue for struggling physician practices during the COVID-19 crisis.

Notwithstanding these flexibilities, physician practices are among the most vulnerable stakeholders in the health care industry during COVID-19, from both a physical and financial health perspective. While the demand for services may renew post-PHE, the investment requirements and upfront risks necessary to scale virtual/data platforms will remain a debilitating financial/regulator stress for practicing physicians, especially those in small and independent practices.

**PAI Recommendation**
We ask policymakers to continue such flexibilities and reimbursement rates for telehealth services (including audio-only services) post-COVID-19, as many physician practices and the patients they serve will continue to remain heavily reliant on telehealth services for the foreseeable future. This will also increase access to physicians and physician services, especially for vulnerable and underserved, urban, and rural patient populations. Additionally, to preserve continuity of care, it is important that, when available, patients maintain their choice of physicians or otherwise have access to seek treatment from a physician in their local communities. Additionally, policymakers should consider the broadband needs of patients in rural and underserved areas ensuring access to telehealth services, including video visits and remote patient monitoring.

Notably, these policies should not:

i) Relieve insurers of their obligation and responsibility to offer adequate provider networks within a reasonable geographic proximity to their insureds.

ii) Expand the scope of practice of non-physician health care professionals beyond that supported by their licensure, education, and training.

iii) Allow a payment differential between telehealth and in-office visits, especially such payment differentials which could create barriers to continuity to care for patients and prevent them from receiving care from their routine physicians.

Furthermore, policymakers must continue to financially support physician practices in developing compatible telehealth and virtual care platforms so that they can continue to perform at the best of their ability and can remain viable amidst competing health systems and hospitals. This funding could look similar to the Health Information Technology (HITECH) Administrative funding for state Health Information Exchange (HIE) activities through the Medicaid Electronic Health Records (EHR) Incentive Program as authorized by the American Recovery and Reinvestment Act of 2009 (ARRA) at 90 percent match rate for design and development costs through 2021.
Remote Patient Monitoring (RPM) and Communications Technology-Based Services (CTBS)

Remote Patient Monitoring (RPM) and Communication Technology-Based Services (CTBS) (such as e-visits, virtual check-ins, and telephone assessments via smart phones, tablets, applications, etc.) have increased physicians’ abilities to provide additional care and care management services in addition to traditional telehealth and telemedicine services. During the PHE, CMS has relaxed flexibilities related to consent for these services, so that while consent is still required and must be documented, it is no longer an obstacle to patients receiving immediate attention and necessary care.

Additionally, RPM has historically played a critical role in the management of chronic diseases. As we transition out of the PHE, it is vital that we continue to expand access to RPM services for underserved and vulnerable populations, including but not limited to rural and urban patient populations, hospice and home care patients, and other long-term care and rehabilitation facilities and locations. Furthermore, CTBS, and any other asynchronous communication services, will remain a vital touch point for all patients, especially underserved populations, who may lack the resources to capitalize on available telehealth platforms.

PAI Recommendation

Policymakers should extend flexibilities for RPM and other CTBS, including waivers of established relationship requirements and more flexible consent requirements. As well, policymakers should include incentives to ensure that patients are receiving care from local physicians and practices in their communities to preserve the patient-physician relationship.

Establish a National Roadmap to Inform Health Care Policies for Future Surges and Future PHEs

Every level of our nation’s government—federal, state, and local—has imposed wide-ranging, unprecedented public policies to address the COVID-19 pandemic. This patchwork approach reflects the fact that this pandemic caught the nation off guard. These policies have impacted virtually every aspect of our health care system, including health care providers, patients and caregivers, insurers, and other stakeholders.

PAI Recommendation

Starting now, it is important to conduct a holistic assessment of the impact of these policies—what worked and what did not—in order to establish a policy framework to guide this and any future PHE. Specifically, we recommend a task force, comprised of policymakers from all levels of government as well as experts in the field, to develop a National Roadmap to inform policies for how to safely continue physician and other important health care services (including preventive care, immunizations, cancer and other screenings, and treatment for patients with chronic medical conditions) during a pandemic and any PHE. This Roadmap should also include strategies for more equitable distribution of personal protection equipment (PPE) for physician practices on the front lines of care delivery.