Table of Contents

5-Ltr to Gov Parson-Shelter in Place 2020 03 23 ................................................................. 2
5-Ltr to Sen Blunt-Independent Practices ............................................................ 3
5-Ltr to Gov Parson-COVID19 2020 03 27 ................................................................. 4
5-Ltr to Gov Parson-COVID19 Addendum 2020 03 30 .................................................. 6
5 AMA HHS letter CARES Act emergency fund 2020 04 07 ........................................ 8
5-AMA CV4 Federation Sign On Letter FINAL Revised ............................................. 10
5-Ltr to Gov Parson-Immunity 2020 04 10 .................................................................. 16
5-MSMA USCIS Ltr 2020 04 10 .............................................................................. 17
5-AAD 20200413 - COVID 19 Teledermatology Access vAHIP ................................. 18
5-AAD 20200413 - COVID 19 Teledermatology Access vBCBSA ................................. 20
5-Dept of Ins Premium Grace Period Ltr 2020 04 15 ..................................................... 22
5-Ltr to MO Healthnet-CARES 2020 05 08 ................................................................. 23
5-MSMA Joint Statement 2020 05 08 ....................................................................... 24
5-MSMA Dept Letter CARES Fitzpatrick 2020 05 14 .................................................. 26
5- Ltr to Gov Parson-Helmet Law 2020 05 27 ............................................................... 27
5-MSMA IMG Ltr to Congress 2020 06 05 .................................................................. 28
5-Federation SignOn Ltr Liability Protection 2020 06 09 .............................................. 29
5-CMS IFR PPS proposed rule sign-on Letter 6-11-20 ................................................ 31
5-Alliant Participation Letter - Missouri ..................................................................... 35
5- Federation SignOn Ltr-501(c)(6) Orgs 2020 06 17 ...................................................... 36
5-AMA SignOn Ltr VA Scope to Richard Stone MD 2020 06 24 .................................. 38
5-School Scholarship Award Ltr 2020 06 22 .............................................................. 41
March 23, 2020

Governor Michael L. Parson
Capitol Building, Room 216
Jefferson City, MO 65101

Governor Parson:

On behalf of the physicians and surgeons practicing in Missouri, the Missouri State Medical Association requests the enactment of a "shelter-in-place" requirement by executive order.

We appreciate the previous actions you have taken regarding this crisis, and understand the interwoven policy issues at play during this critical time. However, we now believe that a statewide "shelter-in-place" order is the only way to curb the exponential spread of COVID-19 in Missouri.

If things progress as is, COVID-19 patients will deplete the state's available hospital beds, ventilators, and precious personal protection equipment. Any additional time without a "shelter-in-place" requirement wastes crucial healthcare resources, including manpower.

As physicians, we understand our role as the first line of defense against this virus. We accept the likelihood that a number of physicians will contract COVID-19 while treating the citizens of Missouri. Despite that known fact, we are prepared to carry out our responsibilities for as long as needed.

We ask for your assistance as we begin this difficult journey.

Regards,

James A. DiRenna, DO, FAAFP
President
March 24, 2020

Dear Senator Blunt,

As physicians across the country voice their concerns about the various effects of the COVID-19 pandemic on the healthcare system, the physicians of the state of Missouri would like to add our voice to the effort.

You may have seen a letter from March 20 addressed to Senate and House leadership, signed by the American Medical Association and several other national physician organizations. In this letter, the groups outline a plea for financial assistance in federal stimulus legislation. Such assistance “should support and sustain physicians and their practices during this unprecedented national emergency through tax relief; no-interest loans; direct payments; payment for virtual visits, including phone calls; and other measures.” The Missouri State Medical Association seconds this call to action.

While all physicians are facing unexpected and unfamiliar challenges as the pandemic progresses, independent physicians and practices are feeling an additional financial burden. Private practices across Missouri have been forced to cancel appointments as they desperately try to keep their patients safe by limiting exposure to this dangerous virus. This decrease in appointments reduces patients’ risk of contracting COVID-19, but the lack of revenue has already pushed many independent practices to a financial breaking point.

In rural areas where hospitals are few and far between, independent practices play an essential role in local economies. Physicians generate $29.2 billion of economic activity in Missouri. Unfortunately, many practices must now weigh their financial options as they lose patients and income. Jobs are at stake as physicians and practice owners make difficult choices between maintaining their support staff’s salaries, making payments for their facilities and supplies, repaying loans, and an array of other financial necessities.

Physicians volunteer to put their patients’ wellbeing before their own. As non-emergent appointments dwindle and offices necessarily instruct patients stay home and protect their health, our members are feeling the financial repercussions. Without assistance from Congress, many Missouri physicians fear they may be unable to keep their practices open to serve their patients and the communities they love.

Please consider independent physician financial stability during discussions involving economic relief legislation. We greatly appreciate your consideration and support during this difficult time for our nation.

Sincerely,

[Signature]

President
Missouri State Medical Association
March 27, 2020

The Honorable Mike Parson
Governor of Missouri
Missouri State Capitol
201 West Capitol Avenue, Room 216
Jefferson City, MO 65101-1556

Dear Governor Parson:

As the novel Coronavirus spreads throughout Missouri, the state’s health care providers are preparing for a dramatic increase in the number of patients needing treatment. With a potentially large influx of patients who are acutely or critically ill, health care providers want to collaborate with insurers to ensure we are free to focus on giving all Missourians the best possible care.

Some progress already has been made on this front. Directives and recommendations from your administration and at the federal level have removed obstacles to access such as cost-sharing for COVID-19 testing and impediments to coverage of COVID-19 treatment. Some insurers have chosen to do much more with some providers. For example, they are changing their practices to speed up throughput for patients who are ready to leave the hospital, and to curtail the administrative burden of coverage authorization requirements. UnitedHealthcare recently waived prior authorization requirements for patients being discharged from the hospital to a post-acute care setting such as a nursing home, rehabilitation facility or long-term care hospital. This should enable more hospital capacity and less time devoted to administrative tasks. Similarly, Anthem is allowing prior authorizations of coverage that already have been granted to remain valid for 90 days, as most elective procedures in hospitals have stopped. Anthem also has waived prior authorizations for discharging patients to skilled nursing facilities.

These changes are laudable, but we hope they can be more broadly adopted to help prepare for the expected surge of patients. To that end, we ask that you encourage the following actions by the state’s health insurers during the national emergency.

- Waive prior authorization requirements for hospital patients discharged to a skilled nursing level of care, or a rehabilitation or long-term acute care hospital.
- Waive copays and expand pharmacy tiers for medications in high demand and short supply, such as albuterol and insulin.
- Ensure coverage of prescriptions with more doses to reduce the need for in-person refills, if consistent with controlled substances law and good medical practice.
- Suspend requirements to purchase or source medications solely from payer-owned pharmacies (PBMs).
The actions above would have immediate effects on improving throughput and capacity, and reducing administrative obligations in critical areas like pharmacies. The following actions would have longer term, but still important, benefits in managing the public health emergency.

- Suspend the measurement periods for any quality-based payment initiatives until the later of September 1, 2020, or one month after the national emergency declaration has expired.
- Allow prior authorization requests already approved to remain in force for at least 90 days after they were first authorized, reducing the need to reprocess mass requests to reschedule planned procedures.
- Suspend routine payer audits.

The COVID-19 public health emergency poses daunting challenges, but the members of our associations remain committed to our communities and to our mission of saving and improving lives. We are in this together and we will come through this together.

Sincerely,

Brian Bowles
Executive Director
Missouri Association of Osteopathic Physicians & Surgeons

Ron L. Fitzwater
Chief Executive Officer
Missouri Pharmacy Association

Herb B. Kuhn
President and CEO
Missouri Hospital Association

Patrick Mills
Executive Vice President
Missouri State Medical Association

Joseph Pierle, MPA
Chief Executive Officer
Missouri Primary Care Association

/djb
March 30, 2020

The Honorable Mike Parson
Governor of Missouri
Missouri State Capitol
201 West Capitol Avenue, Room 216
Jefferson City, MO 65101-1556

Dear Governor Parson:

On March 27, our organizations wrote you regarding an expression of support for a number of actions Missouri’s health insurers could take to enable more provider capacity and/or alleviate administrative burden on providers as they respond to the national emergency. We noted that several major insurers already have taken action on this front. We appreciate your consideration of the request.

Since our March 27 letter, our members have offered additional proposals for your consideration. They are listed below. We ask that you and your staff regard this as an addendum to our earlier letter.

- Modify the earlier proposal to allow prior authorization requests already approved to remain in force for at least 90 days. The additional request is that this standard would be in effect for 90 days after the national emergency expires.
- Ensure coverage for testing and cost of care regardless of the network status of the provider.
- Suspend prior authorization requirements for treatment and care related to COVID-19.
- Refrain from retroactive denials.
- Cover costs of COVID-19 treatment in high-deductible plans of coverage as though the deductible has been met.
- Refrain from discriminating against enrollees in coverage decisions based on the enrollee’s COVID-19 status.
- Temporarily allow coverage for voice-only telemedicine.
- Suspend annual limits that might be imposed on telemedicine visits.
- Waive prior authorization and step therapy for alternate drugs during a drug shortage.
- Allow patients to fill a prescription at an out-of-network pharmacy and receive coverage at in-network benefit levels during a drug shortage.
- Discourage premium increases based on a group’s decreased enrollment or participation.
- Eliminate cost sharing for appropriate vaccines.
- Suspend prior authorization requirements for emergency department treatment.
- Expedite credentialing of new physicians.
- Provide clear and consistent guidelines to process telehealth visits across payers.
• Provide a mechanism to request that insurers provide bridge funding to hospital systems that remain in a level 3 emergency response for more than four weeks to ensure adequate revenue to support critical operations and supply chain efforts.
• Suspend routine contract negotiations and terminations for 90 days.

Thank you for the leadership you and your administration have provided in this public health emergency.

Sincerely,

Brian Bowles
Executive Director
Missouri Association of Osteopathic Physicians & Surgeons

Herb B. Kuhn
President and CEO
Missouri Hospital Association

Joseph Pierle, MPA
Chief Executive Officer
Missouri Primary Care Association

Ron L. Fitzwater
Chief Executive Officer
Missouri Pharmacy Association

Patrick Mills
Executive Vice President
Missouri State Medical Association

/djb
April 7, 2020

The Honorable Alex Azar  
Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

Dear Secretary Azar:

The undersigned organizations represent the hundreds of thousands of physicians who treat our nation’s patients every day. We are writing to request immediate financial assistance for physicians across the country who are taking heroic action to treat patients with the novel coronavirus, providing ongoing care for patients with chronic conditions and urgent needs, and incurring significant financial losses due to postponing non-essential procedures and visits.

Congress intended to provide relief to physician practices who are suffering financial loss due to COVID-19 by designating funding in the Public Health and Social Services Emergency Fund in the Coronavirus Aid, Relief and Economic Security (CARES) Act. The statute requires HHS to interpret eligibility for the funding broadly to include all physicians who are experiencing revenue losses and non-reimbursable expenses as a result of the COVID-19 pandemic.

Physician practices, depending on their location and specialty, face several hardships that we believe should qualify for help. For example, we have heard physicians who are caring for patients with COVID-19 are staying in hotels or renting an apartment to protect their loved ones and maintain a proper social distance. Many physicians who practice in offices and ambulatory surgical centers are not seeing patients for non-essential visits and procedures to preserve medical supplies for treating patients with COVID-19 and to slow the community spread of the virus. We are also concerned that small practices are particularly vulnerable to financial ruin as they have less ready access to capital and are already operating on razor thin margins. In addition, we have heard from many large physician practices and faculty practice plans that have over 500 employees and will not qualify for the small business assistance in the CARES Act. They are faced with the untenable position of laying off staff and physicians due to lower financial revenues while preparing for, and in some areas of the country, responding to a surge in patients with COVID-19.

We recommend HHS provide immediate relief to ensure a sufficient physician workforce is available in this country now and throughout the pandemic. Specifically, we urge HHS to provide one month of revenue to each physician (MD or DO), nurse practitioner, and physician assistant enrolled in Medicare or Medicaid to account for financial losses and non-reimbursable expenses. HHS should use an individual’s average monthly payment amount from October-December 2019, which has been provided to the Medicare Administrative Contractors (MACs), as the basis for determining pre-pandemic monthly revenue. For most specialties, Medicare patients account for 35% of all patients, so to extrapolate to all patients, HHS should use three times the October-December 2019 average as the basis for issuing a payment. Certain specialties have fewer Medicare patients and should be adjusted upward accordingly: psychiatry (20%), allergy/immunology (15%), obstetrics/gynecology (15%), and pediatrics (5%). Pediatricians, obstetrician-gynecologists, and allergists may have many patients insured by Medicaid but few or no patients with Medicare and will require a different approach. The funds are for the purpose of
supporting physician practices in light of lost revenue, such as for paying salaries, benefits, and overhead and making necessary investments to continue providing care such as telehealth.

The CARES Act permits the Secretary to provide funding through a grant or other mechanism and we urge the Department to provide immediate financial relief by issuing funds via the MACs. We believe it will be expedient to administer, while also allowing proper oversight as funding would be based on Medicare claims data and utilize existing enrollment and payment protocols.

Physicians are continuing to put their patients’ needs first to combat this unprecedented public health emergency. We urge you to support them against financial peril while they put their lives and businesses at risk.

Sincerely,

American Medical Association
Academy of Physicians in Clinical Research
AMDA – The Society for Post-Acute and Long-Term Care Medicine
American Academy of Allergy, Asthma & Immunology
American Academy of Cosmetic Surgery
American Academy of Dermatology Association
American Academy of Emergency Medicine
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Family Physicians
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Otolaryngic Allergy
American Academy of Otolaryngology- Head and Neck Surgery
American Academy of Pain Medicine
American Academy of Physical Medicine and Rehabilitation
American Academy of Sleep Medicine
American Association for Hand Surgery
American Association for Physician Leadership
American Association of Child & Adolescent Psychiatry.
American Association of Clinical Endocrinologists
American Association of Clinical Urologists
American Association of Hip and Knee Surgeons
American Association of Neurological Surgeons
American Association of Neuromuscular & Electrodagnostic Medicine
American Association of Orthopaedic Surgeons
American Association of Public Health Physicians
American College of Allergy, Asthma and Immunology
American College of Cardiology
American College of Chest Physicians
American College of Medical Genetics and Genomics
American College of Obstetricians and Gynecologists
American College of Osteopathic Internists
April 9, 2020

To: Pelosi, McCarthy, McConnell, and Schumer:

The American Medical Association and undersigned state medical societies and national physician specialty organizations appreciate the recent actions taken by Congress and the Administration to help physicians, other health care professionalsclinicians, and hospitals on the frontlines of care meet the demands of the rapidly evolving COVID-19 pandemic. In particular, passage of H.R. 748, the “Coronavirus Aid, Relief, and Economic Security Act” (CARES Act), was a meaningful step in preserving the health care infrastructure during today’s crisis and beyond. As you consider next steps and any “phase four” coronavirus relief bill package to confront this emergency of extraordinary—and yet, unknown—proportions, we strongly urge you to take additional steps to protect patient access to care by help preservepreserving the viability of physician practices, as part of the nation’s essential health care system.

Medicare Accelerated and Advanced Payments

We greatly appreciate that the CARES Act expanded the Accelerated and Advance Payment Program for the duration of the COVID-19 public health emergency. We appreciate that the statute postpones the start of recoupment from day one to day 120 after initial payment and allows up to 365 days for repayment. The Centers for Medicare & Medicaid Services (CMS) has worked quickly to provide flexibility to physicians who need financial assistance. However, we have heard significant concerns about the ability of physician practices to repay this amount of money while patients remain at home and physicians delay non-essential procedures and visits to preserve protective equipment and slow the spread of the virus, and there are statutory fixes needed to help physician practices. We provide more detail below about our recommendations to:

- postpone recoupment until 365 days after the advance payment is issued;
- reduce the per-claim recoupment amount from 100% to 25%;
- extend the repayment period for physicians to at least two years;
- waive the interest that accrues during the extended payment period; and
- give HHS authority to issue more than one advanced payment.

We urge Congress to postpone recoupment until 365 days after the advance payment is issued and to extend the repayment period for physicians to at least two years to support those who are trying to stay afloat to treat patients with COVID-19, as well as patients with ongoing and emergent care needs. Currently, physicians are only able to delay financial problems by receiving an advanced payment today that must be repaid by offsetting future claims in four months. We note provisions of the CARES Act provide greater repayment flexibility, such as Section 2302, which allows employers to defer payroll taxes for up to two years and Section 4003, which provides loans of up to five years to other industries facing disruption due to the pandemic. We urge Congress to provide the same flexibility for physicians by delaying recoupment and allowing physicians to extend repayment over at least two years, so they are not merely delaying the financial misery experienced now for later this year.

In addition, we are concerned that recouping the entirety of the advance payment by offsetting 100% of Medicare claims until the balance is extinguished will result in a sudden seizure of Medicare revenues,
thus abruptly halting cash flow as practices continue making adjustments as needed to respond to the pandemic’s different spread in different areas of the country and potential resurgences. We believe the intent of Congress and CMS in expanding the Accelerated and Advance Payment Program is to assist with cash flow issues, which will continue to be an issue beyond the immediate near term as practices face an extremely uncertain timeline for resuming full operations. Therefore, Congress should direct CMS to recoup a per-claim maximum of 25% during the repayment period to ensure that while the Medicare program is being repaid the funding that was advanced via this mechanism, the recoupment process does not result in a sudden stoppage of Medicare revenues to practices at a future time when we are not even sure the current crisis will be over.

In addition, the statute currently requires any outstanding debt after the initial repayment period expires to begin accruing interest, which is at a rate of 10.25%. We urge Congress to reduce the interest amount during the extended repayment period to zero for advanced payments due to the COVID-19 pandemic. This way, physician practices could extend repayment of these zero-interest loans over the course of 2021 and focus immediately on the needs of their patients and communities, such as implementing telehealth, and keeping the lights on while other procedures and visits are postponed.

Finally, we urge Congress to give HHS authority to issue more than one advanced payment. Given the uncertainty facing physician practices as the pandemic is on a different surge timeline in communities across the country, we fear physician practices may not resume normal operation in the immediate term and will need additional cash flows to remain afloat for patients after the pandemic is over. Many physicians have already had to make difficult decisions about reducing operations, taking pay cuts, and furloughing staff even while they are preparing for and treating a surge of COVID-19 cases.

Medicare and Medicaid Payment

While the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 included modest positive payment updates in prior years, it left a six-year gap from 2020 through 2025 during which there are no annual updates at all. Congress could not have predicted that the first year without a positive payment update to the Medicare Physician Fee Schedule would come at the beginning of a public health emergency like the one that faces our nation today. Even before the pandemic, physician practices faced increasing costs and payments that did not keep pace with inflation. This is in contrast with other providers who continued to receive positive updates in 2020. We believe it is vital that Congress implement a positive update similar to those other providers received in 2020, as physicians put their lives on the line to treat patients with COVID-19 and incur significant financial hardship due to cancelled non-urgent but still medically necessary procedures and visits to slow the spread of the virus.

We also urge Congress to take additional steps to provide financial assistance to physicians caring for patients during the pandemic, including:

- increase increasing Medicaid and TRICARE payment rates to assure parity with Medicare fee-for-service payments for the duration of the public health emergency;
- waive waiving budget neutrality for the Medicare payment changes for evaluation and management (E/M) services that will be implemented on January 1, 2021; and
- extend extending sequestration relief through December 31, 2021 to continue providing financial relief as physician practices resume normal operations.

Direct Financial Support
While CARES Act will provide important relief, it does not provide sufficient direct support to help sustain physician practices. Many are struggling to meet the needs of their patients and staff as they confront worsening revenue shortages resulting from deferring visits and procedures as part of the system-wide effort to conserve personal protective equipment and support the social distancing that is necessary to curb community spread of COVID-19. There are physician practices in all types of specialties and practice settings that have either temporarily closed or will be forced to do so in coming weeks. While small practices that are less able to easily access capital are most at risk, we are also hearing from large physician practices and faculty practice plans with more than 500 employees that are ineligible for the expanded small business loans in the CARES Act. Physicians in private practice are trying to do the right thing by adhering to current guidelines about postponing or canceling elective procedures and non-urgent office visits, but given continuing overhead and payroll costs, many are experiencing cash flow issues and need assistance to avoid an implosion of the entire private medical practice infrastructure.

Accordingly, we strongly recommend that Congress authorize direct financial support, grants, and interest free loans and other mechanisms, such as a 9/11-type COVID fund, for physician practices of all sizes to ensure that they can remain afloat to meet the demands of this crisis and the ongoing health care needs of all of their patients. Reimbursable expenses should include payroll costs and other overhead costs, as well as payments made to outside firms for billing and IT purposes, especially for those practices that are too small to maintain part/full-time staff for these functions. We support provisions such as those in legislation sponsored by Senators Bennet and Barrasso, the Immediate Relief for Rural Facilities and Providers Act (S.3559), that would provide an emergency, one-time grant for all providers and ambulatory surgery centers equal to their total payroll from January 1 - April 1, 2019. The grant should also include all overhead costs.

Small Business Loans

We also encourage Congress to provide additional funding for the newly authorized and expanded small business loans under the Small Business Administration. It is clear that the new small business loan program authorized in the CARES Act, the Payroll Protection Program (PPP), is already overwhelmed with applicants seeking assistance. The PPP needs an urgent infusion of additional funding in order to adequately respond to the need for these loans. In addition, we have heard from larger physician practices with more than one location but with 500 employees or less per location who are currently ineligible for the PPP loans. The AMA recommends that Congress include provisions to apply the same exception to these physician practices that applies to the Accommodation and Food Services Industry that operate at more than one physical location with 500 or fewer employees per location. We also recommend extending to physician practices the affiliation rule waiver that has already been applied to the Accommodation and Food Services Industry.

Telehealth

Both Congress and the Administration have expanded Medicare coverage substantially for telehealth services to improve access to care for patients with ongoing health care needs as well as for COVID-19. This includes coverage for telephone services, which is particularly important for patients with limited technological resources in their homes. In response, many private plans are mirroring the federal government’s policies. We urge Congress to also require ERISA group health plans to provide coverage
for the same telehealth and telephone services being provided by Medicare for the duration of the COVID-19 pandemic, to ensure all insured patient have access to these services during this critical time.

Support for Resident Physicians and Students

Many residents and medical students are playing a critical role in responding to the COVID-19 crisis and providing care to patients on the frontlines. For residents, COVID-19 is inflicting additional strain as they are redeployed from their primary training programs and put their health on the line caring for the sickest patients, many without appropriate personal protective equipment. Some medical schools, such as New York University, are graduating their students early to deploy them to care for patients during this public health crisis. For these residents and early graduated medical students, whose debt averages over $200,000, we urge Congress to provide at least $20,000 of federal student loan forgiveness or $20,000 of tuition relief. These benefits should also be made available to third- and fourth-year medical students who are willing, and deemed competent, to begin providing early direct patient care for patients with COVID-19, or who are making other significant contributions to the pandemic response through research, public health, and telemedicine.

We also ask for flexibility in CMS’s GME reimbursement to hospitals to accommodate variations in training due to the COVID-19 response. This flexibility should lengthen the initial residency period (IRP) for residents to allow them to extend their training, if necessary, to meet program and board certification requirements. CMS should also expand the cap at institutions where residents must extend their training to support an increased number of residents as new trainees begin while existing trainees remain to complete their programs.

Hazard Pay

Physicians across the United States have been called on to put in extra hours and to undertake enormous, unanticipated, personal risk during the COVID-19 pandemic as they care for a flood of progressively sicker patients. Like other frontline medical providers, physicians, residents, and early medical graduates have been required to work under severe circumstances, which have caused them extreme physical discomfort and distress, that cannot be adequately alleviated by protective devices, due to the shortage of personal protective equipment across the country. As such, physicians, residents, and early medical graduates, should be provided hazard pay for undertaking physical hardships and performing the hazardous work of caring for patients during the COVID-19 crisis. All physicians, residents, and early medical graduates that are involved in caring for, or aiding in the care of COVID-19 patients, not working from home, should be entitled to at least $25,000 of hazard pay that would apply throughout the public health emergency and retroactive from January 31, 2020. Additionally, benefits should also be provided to families of physicians, residents, and early medical graduates who die as a result of COVID-19.

Emergency Medical Treatment and Labor Act (EMTALA)

While we applaud the recent EMTALA guidance offered by CMS during the pandemic, we believe the March 30, 2020 EMTALA Requirements and Implications Related to COVID-19 guidance does not go far enough to protect the nation’s emergency departments. Therefore, we ask Congress to clarify the HHS Secretary’s ability to issue waivers under Section 1135 of the Social Security Act so that state and local protocols may be adopted to provide more nimble methods to address the pandemic.
Liability

The pandemic has created a public health emergency that is rapidly altering the provision of health care services across the country based on guidance and recommendations from the Centers for Disease Control and Prevention, Department of Health and Human Services, and other federal, state, and local government directives. Although necessary, these measures have raised serious concerns about the potential liability of physicians and other clinicians who are responding to the pandemic and continue to provide high-quality patient care while adhering to these guidance and recommendations. Examples of increased liability risk facing physicians and other clinicians include the following:

- suspension of most elective in-person visits and replace them with virtual visits to the extent possible as requested by the CDC and other public health authorities;
- providing treatments or care outside their general practice areas and for which they may not have the most up-to-date knowledge;
- coming out of retirement to alleviate workforce shortages related to the growing health crisis caused by the COVID-19 pandemic;
- inadequate supplies of safety equipment that could result in the transmission of the virus from patient to physician and then to additional patients, or directly from one patient to another;
- shortages of equipment, such as ventilators, that can force facilities and physicians to ration care;
- inadequate testing that could lead to delayed or inaccurate diagnosis; and
- delays in treatment for patients with conditions other than coronavirus.

In these and other scenarios, physicians and other clinicians face the threat of medical liability lawsuits due to circumstances that are beyond their control. These lawsuits may come months or even years after the current ordeal when the public memory of their sacrifices may be forgotten.

Congress has already acknowledged that liability is a significant impediment to physicians and other clinicians. In section 3215 of the recently enacted CARES Act, Congress included important liability protections for health care volunteers who respond to the COVID-19 crisis. Also, Congress has passed laws that provide various liability protections for physicians and other clinicians who volunteer or who provide health care services under certain, limited circumstances, including: the Public Readiness and Emergency Preparedness Act (PREP Act); the Volunteer Protection Act of 1997; and section 194 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). There are various state liability protections available as well.

Given the enormity of the COVID-19 crisis, however, we strongly urge Congress to consider broader liability protections for physicians and other clinicians and the facilities in which they practice as they continue their non-stop efforts to treat COVID-19 under unprecedented conditions. For example, similar to New York, Congress could extend broad civil immunity to physicians and other clinicians for any injury or death alleged to have been sustained directly as a result of an act or omission in the course of providing medical services in response to the COVID-19 pandemic, with exceptions for gross negligence or willful misconduct. Another approach for consideration could be to extend during this national public health emergency Federal Tort Claims Act liability protections to physicians and other clinicians providing care to COVID-19 patients or otherwise responding to guidance or protocols from a government entity.
We would welcome the opportunity to work with Congress and other stakeholders to further develop these concepts or consider other options that will achieve the goal of ensuring that our physicians and other clinicians can focus on the task at hand of helping those affected by COVID-19 without the threat of lawsuits.

We sincerely appreciate all that you have done in a short period of time to protect access to care by providing needed resources and policy changes to enable physicians to continue caring for patients in their time of need during this pandemic. Given the magnitude of the growing revenue shortfalls confronting physician practices across the country, we continue to need your support to preserve their viability so they can meet the needs of all patients. Thank you for considering our requests.
April 10, 2020

Office of Governor Michael L. Parson
P.O. Box 720
Jefferson City, MO 65102

Governor Parson:

On behalf of Missouri’s physicians and surgeons, we applaud your consistent messaging regarding the importance of social distancing and self-quarantine during the COVID-19 crisis. We are also appreciative of your recent decisions regarding schools, and your efforts to ensure the state’s physicians and nurses have access to adequate personal protection equipment (PPE).

It has come to our attention that you may soon consider an executive order that would grant civil immunities to individuals and entities who are treating patients during this critical time. We feel this is a laudable effort and we support your consideration of it.

However, we would encourage you to avoid including in such order any effort that would hold hospitals harmless regarding their PPE usage policies. Over the course of the COVID-19 threat, there have been disagreements between healthcare professionals and hospitals over draconian PPE policies.

It would be unfortunate to eliminate any recourse for frontline physicians and nurses who are treating COVID-19 patients. Especially since they are the providers putting their lives on the line every day to heal Missourians.

Thank you for your consideration of this request.

Stay safe,

George J. Hruza, MD, MBA, FAAD
President
April 10, 2020

The Honorable Roy Blunt
U.S. Senate
Washington, DC 20510

Dear Senator Blunt,

We are writing on behalf of American-trained international physicians and the Missouri patients who have been cared for in Missouri by these physicians for many years. There are about 2,000 international physicians who are on a H-1B work visa / J1-waiver / Conrad 30 program. The majority of these physicians work in Medically Underserved Areas (MUA) / Healthcare Professional Shortage Areas (HPSA) / academic medical research institutions and rural American communities. They are in the frontline fighting against deadly pandemic COVID-19.

We want to bring to your attention that these international physicians can only work for the employer who sponsors their H-1B visa, and in only one specific location as mentioned in their application to USCIS (U.S. Citizenship and Immigration Services). It makes it very difficult for these well-trained physicians to assist communities in need. There are thousands of international physicians who are restricted by visa limitations all over the U.S.

Another issue these American-trained international physicians are facing is that if the primary H-1B petitioner (physician) becomes incapacitated and unable to work, then the physician with the visa and his immediate dependents (spouse and children who are not U.S. citizens) will immediately become out of status and have to leave the U.S. We request leniency from USCIS to promote maximum patient care.

We request you contact Kenneth Cuccinelli, Acting Director of U.S. Citizen and Immigration Services to “INCREASE THE ACCESS TO THESE PHYSICIANS” by removing the employer-based H-1B visa work restrictions during the COVID-19 health emergency. This will allow these American-trained international physicians to expand the geographical radius of services and help fellow Americans fight this deadly COVID-19 pandemic. We have fully trained and experienced physicians who are willing to help but cannot because of visa restrictions.

Sincerely,

George J. Hruza, MD, MBA, FAAD
President
April 13, 2020

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

RE: Temporary Expansion of Telemedicine Services during COVID-19

Dear Mr. Eyles,

On behalf of the undersigned organizations, which represent physicians across the country, we are writing regarding a need for expanded access to telemedicine services for the duration of the COVID-19 pandemic. We believe that as the leading society that represents insurers throughout the United States it is imperative that America's Health Insurance Plans (AHIP) provides recommended guidance to its members to harmonize the disparate requirements physicians are facing.

In order to effectively flatten the curve of COVID-19 diagnosis, the Centers for Disease Control (CDC) is recommending face-to-face interaction be severely limited. Additionally, the delayed symptoms associated with COVID-19 could lead to spreading of the disease if either a patient or physician unknowingly is a carrier of the virus. Telemedicine plays a crucial role in flattening the curve. We strongly support coverage and payment for telemedicine services provided by Board-certified physicians. It is important that patient access to care – when provided by telemedicine – is of high quality, contributes to care coordination, meets state licensure and other legal requirements, maintains patient choice and transparency, and protects patient privacy. At this time many insurers are adopting temporary policies that expand their normal telemedicine coverage policies, but the policies are inconsistent and are creating a significant burden on practices. We are asking for AHIP to provide recommended guidance to its member companies and licensees that enables physicians to deliver telemedicine across all platforms that is consistent with Centers for Medicare and Medicaid (CMS) guidance, reimburses in parity with in-office rates, and follows CMS coding guidance for claims to reduce variations in coding requirements.

Platform Requirements for Telemedicine Delivery

We encourage your member organizations to recognize the value of the physician-patient relationship and expand access to and coverage for telemedicine encounters. We are concerned that platform requirements and third-party vendors’ requirements by an insurer delay or deny patients access to their own physicians through telemedicine services. In this time of national crisis and uncertainty, allowing patients the trust and confidence of continuing care with their physician, whenever possible, is critical. This flexibility for the duration of the pandemic provides access to telemedicine that is consistent with the CMS, which is allowing physicians to diagnose and treat patients through the physicians’ platform of choice while utilizing office-based evaluation and management (E/M) codes 99201-99215.

Reimbursement for Telemedicine Services

Reimbursement levels for telemedicine encounters vary across payers, with some insurers shifting physicians to a different fee schedule or reimbursing at a percentage of the standard fee schedule. Under different circumstances this change in reimbursement structure could be justified. However, we ask you to encourage member organizations to maintain reimbursement levels that are in parity with in-office fee
schedules. We also ask that member plans maintain parity for ‘audio only’ visits, as many patients do not have video-capable devices and/or adequate internet or cellular coverage to conduct a visit by any means other than on their land lines. The unanticipated and sudden transition to telemedicine for a significant portion of care delivery during the COVID-19 pandemic removes the efficiencies that could potentially be realized through telemedicine. Delivery of physician services still requires significant coordination by clinical staff to manage pre- and post-visit care as well as other staff costs related to the verification of patient benefits, scheduling, and claims submission. CMS recognizes that these costs will continue to be incurred by physician practices, and as a result, has agreed to pay in-parity with in-office rates and we encourage your members to follow the CMS lead.

Coding for Telemedicine Encounters

Finally, insurers are adopting guidelines on how physicians should notify insurers that a telemedicine encounter occurred. We recognize that some insurers have system limitations and have adopted specific coding guidelines to work within their platform. However, our physicians are encountering significant variation in place of service (POS) and modifier requirements. To harmonize insurer requirements, we recommend that AHIP encourages insurers to adopt CMS coding guidance, which now allows utilization of POS 11 and modifier 95 to report telemedicine encounters that would have been delivered in-office for the duration of the COVID-19 pandemic.

In addition to the POS and modifier requirement, we also recommend insurers recognize the change in E/M guidance CMS has adopted which will now allow reporting of 99201 through 99215 based on time or acuity for the telemedicine encounters. The time-based requirement is consistent with changes to these codes that will be implemented in 2021 and decreases the ambiguity physicians may face in determining the acuity level associated with an encounter.

Conclusion

We recognize that the COVID-19 pandemic is creating a significant change in the delivery of healthcare services. When this pandemic subsides, we request an opportunity to engage with AHIP to understand how we can work together to identify how telemedicine could improve the delivery of patient care. We look forward to additional opportunities to work together on this issue and to provide feedback that may help guide policy development. Please contact David Brewster, Associate Director of Practice Advocacy, American Academy of Dermatology Association, at dbrewster@aad.org or (202) 609-6334 if you have any questions or if we can provide additional information. Thank you for your attention to our concerns.

Sincerely,

American Academy of Dermatology Association
American Academy of Neurology
American Academy of Physical Medicine and Rehabilitation
American Association of Child and Adolescent Psychiatry
American Association of Oral and Maxillofacial Surgeons
American Association of Orthopaedic Surgeons
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Rheumatology
American Gastroenterological Association
American Osteopathic Association
American Osteopathic College of Dermatology
April 13, 2020

Vincent Nelson, MD, MBA, FASA
Vice President, Medical Affairs and Interim Chief Medical Officer
Blue Cross Blue Shield Association
225 N. Michigan Avenue
Chicago, IL  60601

RE: Temporary Expansion of Telemedicine Services during COVID-19

Dear Dr. Nelson,

On behalf of the undersigned organizations, which represent physicians across the country, we are writing regarding a need for expanded access to telemedicine services for the duration of the COVID-19 pandemic. We believe that the Blue Cross Blue Shield Association (BCBSA) should provide recommended guidance to its members companies and licensees to harmonize the disparate requirements physicians are facing.

In order to effectively flatten the curve of COVID-19 diagnosis, the Centers for Disease Control (CDC) is recommending face-to-face interaction be severely limited. Additionally, the delayed symptoms associated with COVID-19 could lead to spreading of the disease if either a patient or physician unknowingly is a carrier of the virus. Telemedicine plays a crucial role in flattening the curve. We strongly support coverage and payment for telemedicine services provided by board-certified physicians. It is important that patient access to care – when provided by telemedicine – is of high quality, contributes to care coordination, meets state licensure and other legal requirements, maintains patient choice and transparency, and protects patient privacy. At this time many insurers are adopting temporary policies that expand their normal telemedicine coverage policies, but the policies are inconsistent and are creating a significant burden on practices. We are asking for BCBSA to provide recommended guidance to its member companies and licensees that enables physicians to deliver telemedicine across all platforms that is consistent with Centers for Medicare and Medicaid (CMS) guidance, reimburses in parity with in-office rates, and follows CMS coding guidance for claims to reduce variations in coding requirements.

Platform Requirements for Telemedicine Delivery

We encourage Blues plans to recognize the value of the physician-patient relationship and expand access to and coverage for telemedicine encounters. We are concerned that platform requirements and third-party vendors’ requirements by an insurer delay or deny patients access to their own physicians through telemedicine services. In this time of national crisis and uncertainty, allowing patients the trust and confidence of continuing care with their physician, whenever possible, is critical. This flexibility for the duration of the pandemic provides access to telemedicine that is consistent with the CMS, which is allowing physicians to diagnose and treat patients through the physicians’ platform of choice while utilizing office-based evaluation and management (E/M) codes 99201-99215.

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Reimbursement levels for telemedicine encounters vary across payers, with some insurers shifting physicians to a different fee schedule or reimbursing at a percentage of the standard fee schedule. Under different circumstances this change in reimbursement structure could be justified. However, we ask you to encourage BCBSA member plans to maintain reimbursement levels that are in parity with in-office fee schedules. We also ask that member plans maintain parity for ‘audio only’ visits, as many patients do not have video-capable devices and/or adequate internet or cellular coverage to conduct a visit by any means other than on their land
lines. The unanticipated and sudden transition to telemedicine for a significant portion of care delivery during the COVID-19 pandemic removes the efficiencies that could potentially be realized through telemedicine. Delivery of physician services still requires significant coordination by clinical staff to manage pre- and post-visit care as well as other staff costs related to the verification of patient benefits, scheduling, and claims submission. CMS recognizes that these costs will continue to be incurred by physician practices, and as a result, has agreed to pay in-parity with in-office rates and we encourage your members to follow the CMS lead.

**Coding for Telemedicine Encounters**

Finally, insurers are adopting guidelines on how physicians should notify insurers that a telemedicine encounter occurred. We recognize that some insurers have system limitations and have adopted specific coding guidelines to work within their platform. However, our physicians are encountering significant variation in place of service (POS) and modifier requirements. To harmonize insurer requirements, we recommend that BCBSA encourages Blues plans to adopt CMS coding guidance, which now allows utilization of POS 11 and modifier 95 to report telemedicine encounters that would have been delivered in-office for the duration of the COVID-19 pandemic.

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**Conclusion**

We recognize that the COVID-19 pandemic is creating a significant change in the delivery of healthcare services. When this pandemic subsides, we request an opportunity to engage with BCBSA to understand how we can work together to identify how telemedicine could improve the delivery of patient care. We look forward to additional opportunities to work together on this issue and to provide feedback that may help guide policy development. Please contact David Brewster, Associate Director of Practice Advocacy, American Academy of Dermatology Association, at dbrewster@aad.org or (202) 609-6334 if you have any questions or if we can provide additional information. Thank you for your attention to our concerns.

Sincerely,

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American Association of Oral and Maxillofacial Surgeons
American Association of Orthopaedic Surgeons
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Rheumatology
American Gastroenterological Association
American Osteopathic Association
American Osteopathic College of Dermatology
American Osteopathic Information Association
American Podiatric Medical Association, Inc.
April 15, 2020

Chlora Lindley-Myers
Director
Missouri Department of Commerce and Insurance
301 West High Street
P.O. Box 690
Jefferson City, MO 65102

Director Lindley-Myers:

On behalf of the physicians and surgeons practicing in Missouri, we wanted to thank you for taking the time to talk on the phone regarding our previous communications. We appreciate your rapid response to our concerns.

As you are aware, the COVID-19 crisis has had a widespread and devastating economic impact in the United States. Missouri has not been immune to this, nor have the state’s physicians. Many of the state doctors are feeling a pronounced financial pinch due to the evaporation of non-COVID related healthcare services. Many small and rural practices are closing. Even larger physician-owned entities are laying off employees and further reducing operations. Much of this is due to the sudden absence of elective procedures.

Because the procedures for which physicians are insured are not being performed, a number of states have granted some relief to healthcare professionals by encouraging medical professional liability (MPL) insurers to institute a grace period for premium payments, cancellations, and non-renewals. A handful of states have issued Executive Orders to this effect, but we believe a request from the Department may be sufficient. We understand that some MPL insurers have voluntarily begun providing premium relief, and feel rest of the industry will follow suit with encouragement from the Department.

We favor a 60-day grace period, which has been the standard in other states.

Thank you for your prompt consideration of this request.

Regards,

George Hruza, MD
President
May 8, 2020

Todd Richardson
Director
MO HealthNet Division
615 Howerton Court
Jefferson City, MO 65109

Dear Director Richardson:

On behalf of Missouri’s physicians and surgeons, I am writing to inform you of the Missouri State Medical Association’s proposal for distribution of a portion of the state’s CARES funds.

Physician offices, regardless of ownership, are significant economic engines in communities all across the state. According to a study by the American Medical Association, the average Missouri physician generates $2.1 million in economic activity. In a normal economy, physicians in this state support almost 174,000 jobs and $13.8 billion in wages and benefits.

The COVID-19 pandemic and its economic fallout has not spared private physicians and their practices. Many independent physicians necessarily had to stop seeing patients as a result of the statewide stay-at-home order. Others had to reschedule appointments in order to preserve personal protective equipment, or to adhere to strict social distancing.

According to a survey by the Medical Group Managers Association (MGMA), 97% of physician practices have experienced a negative financial impact from COVID-19. There has been a 55% average decrease in revenue. Because of revenue and patient volume reductions, over 50% of practices have furloughed or laid off staff.

The Missouri State Medical Association proposes using 10% of the remaining CARES funds to assist struggling physician practices exclusive of FQHCs. This $150 million will be used by practices for payroll and other COVID-related expenses to ensure continued operation. We feel this modest amount ensures accountability for the funds, and will enhance the chances for full utilization of this modest amount.

We propose using a loan forgiveness plan similar to the SBA’s Paycheck Protection Program model for distribution of the funds, using Central Bank as trustee. Each EIN employing a physician in Missouri will be eligible for $15,000 per physician to cover lost revenue due to COVID-19. In addition, we suggest reserving at least 50% of available funds for non-hospital employed physicians.

This is a rough sketch, but we would greatly appreciate the support of the MO HealthNet Division as recommendations regarding distribution are collected and analyzed.

Please contact MSMA’s Jeff Howell at jhowell@msma.org if you have any questions.

Regards,

George J. Hruza, MD, MBA, FAAD
President
May 8, 2020

STATEMENT

STATEWIDE ORGANIZATIONS URGE MISSOURIANS TO CONTINUE PREVENTION BEST PRACTICES DURING REOPENING

“Thanks to the leadership of Gov. Mike Parson and his administration, along with the adherence to social distancing and stay at home orders, we’ve slowed the spread of COVID-19 in the state. That unselfish sacrifice by so many is what has brought us to begin the phased opening our state’s economy this week. The following organizations — representing businesses, emergency services, governments, health care providers and individuals throughout the state — issued a statement on March 24 that urged all Missourians to support all the mitigation efforts available to slow the COVID-19 chain of transmission.

The phased-in resumption of our economy can only be successful if everyone in the state continues to follow the proven and well documented community-based interventions and prevention practices such as social distancing, hand washing, staying at home when sick, covering coughs and sneezes and wearing a face mask when in public places.

But, social distancing doesn’t mean not seeking care. It is important that all Missourians seek medical care if they are having an emergency and to receive ongoing treatment for chronic medical conditions. Health care providers across
the state are safe and ready to help. The sooner you seek care, the more likely it is you will have a better outcome.

Every Missourian has a role to play during this ongoing emergency and the reopening of our economy. The challenge continues to be real and immediate until the general population has immunity and a vaccine is developed and fully deployed. To help keep Missouri moving forward, we urge everyone in the state to continue to do their part."

LeadingAge Missouri
Missouri Alliance of Home Care
Missouri Ambulance Association
Missouri Association of Counties
Missouri Association of Osteopathic Physicians and Surgeons
Missouri Bankers Association
Missouri Chamber of Commerce and Industry
Missouri Chapter, American College of Physicians
Missouri College of Emergency Physicians
Missouri Emergency Medical Services Association
Missouri Farm Bureau
Missouri Health Care Association
Missouri Hospital Association
Missouri Nurses Association
Missouri Primary Care Association
Missouri State Medical Association

# # #
May 14, 2020

Scott Fitzpatrick
Treasurer
State of Missouri
P.O. Box 210
Jefferson City, MO 65102

Dear Hon. Scott Fitzpatrick:

On behalf of Missouri’s physicians and surgeons, I am writing to inform you of the Missouri State Medical Association’s proposal for distribution of a portion of the state’s CARES funds.

Physician offices, regardless of ownership, are significant economic engines in communities all across the state. According to a study by the American Medical Association, the average Missouri physician generates $2.1 million in economic activity. In a normal economy, physicians in this state support almost 174,000 jobs and $13.8 billion in wages and benefits.

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The Missouri State Medical Association proposes using 10% of the remaining CARES funds to assist struggling physician practices exclusive of FQHCs. This $150 million will be used by practices for staff payroll and other COVID-related expenses to ensure continued operation. We believe this modest amount ensures accountability for the funds, and will enhance the chances for full utilization of the allocation.

We propose using a loan forgiveness plan similar to the SBA’s Paycheck Protection Program model for distribution of the funds, using Central Bank as trustee. Each EIN employing a physician in Missouri will be eligible for $15,000 per physician to cover lost revenue due to COVID-19. In addition, we suggest reserving at least 50% of available funds for non-hospital employed physicians and their practices.

This is a rough sketch, but we would greatly appreciate your support as recommendations regarding distribution are collected and analyzed.

Please contact MSMA’s Jeff Howell at jhowell@msma.org if you have any questions.

Regards,

George J. Hruza, MD, MBA, FAAD
President
May 27, 2020

Honorable Michael L. Parson  
State Capitol Building  
PO Box 720  
Jefferson City, MO 65102  

Dear Governor Parson:

On behalf of the physicians, residents, and medical students who comprise the Missouri State Medical Association, I urge you to veto HB 1963, which would repeal Missouri’s motorcycle helmet law for riders over 26 years of age.

Head injury is the leading cause of death in motorcycle accidents. While appropriate protective headgear does not prevent every head injury, the National Highway Traffic Safety Administration (NHTSA) reports that helmets are 67 percent effective in preventing brain injuries and 73 percent effective in preventing fatalities in motorcycle accidents.

It is well established that the cost of treating and caring for brain injury patients is astronomical. That is a price all Missourians pay, whether it be through uncompensated care, state-funded care, or even higher insurance premiums. However, the cost of medical care pales in comparison to the price of emotional pain and suffering borne by families and communities torn apart by a death or head injury that could have been prevented by a motorcycle helmet.

Missouri’s mandatory helmet law serves the state well, saving lives, preventing injuries and saving countless dollars in unnecessary health care costs. Please do not permit this law to be repealed. Please veto HB 1963.

Thank you for your consideration.

Sincerely,

George J. Hruza, MD MBA FAAD FACMS  
President, Missouri State Medical Association  
Adjunct Professor of Dermatology, St. Louis University
June 5, 2020

The Honorable Senator Roy Blunt
The Honorable Senator Joshua Hawley
The Honorable Representative Ann Wagner
The Honorable Representative Emanuel Cleaver II
The Honorable Representative Billy Long
The Honorable Representative Jason Smith
The Honorable Representative Lacy Clay, Jr.
The Honorable Representative Blaine Luetkemeyer
The Honorable Representative Sam Graves
The Honorable Representative Vicky Hartzler

Delivered via email

Re: Support for the Healthcare Workforce Resilience Act

Dear Senators and Representatives of the Missouri Congressional delegation,

On behalf of the Missouri State Medical Association, I am writing to request your support of S.3599, known as the Healthcare Workforce Resilience Act. The legislation is a bipartisan proposal from Sen. Perdue, Sen. Durbin, Sen. Young, and Sen. Coons and co-sponsored by Sen. Blunt, that will address the shortage of physicians and nurses during the nation’s COVID-19 pandemic and will enhance the healthcare workforce.

Specifically, the bill authorizes the recapturing of 15,000 unused immigrant visas for physicians as well as 25,000 visas for nurses. The bill further allows for the issuing of visas for the immediate families of these physicians and nurses and not have those visas count toward the 40,000 limit.

The Missouri State Medical Association believes that the Healthcare Workforce Resilience Act will help ensure that the nation has enough physicians and nurses to care for the public during the COVID-19 crisis and beyond. This is particularly important to Missouri which ranks third in Health Professional Shortage Areas (HPSAs) behind California and Texas.

The Missouri healthcare workforce relies upon health professionals from other countries to provide high-quality patient care. During this pandemic, it is more critical than ever to ensure that patients have access to these providers without limitations that the current J-1, H-1B, and O-1, visa programs impose. Consequently, we believe that the passage of S.3599 will go a long way towards solving this problem.

Thank you for your attention to this important matter.

Sincerely,

George J. Hruza, MD MBA FAAD
President
June 9, 2020

The Honorable Nancy Pelosi
Speaker of the House of Representatives
U.S. Capitol Building, H-222
Washington, DC 20515

The Honorable Mitch McConnell
Senate Majority Leader
U.S. Capitol Building, S-230
Washington, DC 20510

The Honorable Kevin McCarthy
House Republican Leader
U.S. Capitol Building, H-204
Washington, DC 20515

The Honorable Charles Schumer
Senate Democratic Leader
U.S. Capitol Building, S-221
Washington, DC 20510

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

The undersigned state, specialty, and national medical associations represent hundreds of thousands of frontline medical and mental health physicians who are diagnosing, testing, treating, and counseling millions of our nation’s patients in response to the COVID-19 pandemic. During this unprecedented national health emergency, physicians and other health care professionals have been putting themselves at risk every day while facing shortages of medical supplies and safety equipment, and making critical medical decisions based on changing directives and guidance. These physicians and other health care professionals are now facing the threat of years of costly litigation due to the extraordinary circumstances.

As the House and Senate continue to work on the next COVID-19 relief package, we strongly urge you to include the targeted and limited liability protections that are in the bipartisan bill, H.R. 7059, the “Coronavirus Provider Protection Act.”

The public health emergency triggered by the COVID-19 pandemic has created unprecedented challenges to our nation’s health care system. In addition to facing inadequate supplies and safety equipment, physicians, hospitals, and other frontline health care professionals have been faced with rapidly changing guidance and directives from all levels of government. Examples include suspending elective in-person visits and procedures, being assigned to provide care outside the physician’s general practice area, rationing care due to shortages of equipment such as ventilators, inadequate testing that could lead to delayed or inaccurate diagnosis, and delays in treatment for patients with conditions other than COVID-19. In these and other scenarios, physicians face the threat of costly and emotionally draining medical liability lawsuits due to circumstances that are beyond their control. These lawsuits may come months or even years after the current ordeal is over.

The liability protections we call on Congress to pass are not universal; they are intended to provide targeted and limited protections where health care services are provided or withheld in situations that may be beyond the control of physicians/facilities (e.g., following government guidelines, directives, lack of resources) due to COVID-19. The protections extend to those who provide care in good faith during the COVID-19 public health emergency (plus a reasonable time, such as 60 days, after the emergency declaration ends), and not in situations of gross negligence or willful misconduct.

As physicians and other health care professionals, and the facilities in which they provide their services, continue their heroic efforts to stop the spread of COVID-19 while caring for COVID-19 patients as well as meeting the needs of other patients, they will remain vulnerable to the threat of unwarranted and unfair lawsuits. We therefore strongly urge Congress to consider targeted and limited liability protections for physicians, other health care professionals, and the facilities in which they practice as they continue their efforts to treat COVID-19 under unprecedented conditions.

We thank you for your consideration.
Sincerely,

American Medical Association
AMDA – The Society for Post-Acute and Long-Term Care Medicine
American Academy of Allergy, Asthma & Immunology
American Academy of Dermatology Association
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Family Physicians
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Otolaryngic Allergy
American Academy of Otolaryngology- Head and Neck Surgery
American Academy of Pediatrics
American Academy of Physical Medicine and Rehabilitation
American Academy of Sleep Medicine
American Association for Geriatric Psychiatry
American Association for Hand Surgery
American Association for Physician Leadership
American Association of Child & Adolescent Psychiatry
American Association of Clinical Endocrinologists
American Association of Clinical Urologists
American Association of Hip and Knee Surgeons
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American Association of Public Health Physicians
American College of Allergy, Asthma and Immunology
American College of Cardiology
American College of Chest Physicians
American College of Emergency Physicians
American College of Gastroenterology
American College of Medical Genetics and Genomics
American College of Obstetricians and Gynecologists
American College of Osteopathic Internists
American College of Osteopathic Surgeons
American College of Physicians
American College of Radiation Oncology
American College of Radiology
American College of Rheumatology
American College of Surgeons
American Gastroenterological Association
American Geriatrics Society
American Medical Group Association
American Medical Women's Association
American Osteopathic Association
American Psychiatric Association
June 11, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: File Code CMS-1729-P
Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2021 Proposal to Allow Non-physician Practitioners to Perform Certain IRF Coverage Requirements that Are Currently Required to Be Performed by a Rehabilitation Physician

Dear Administrator Verma:

The undersigned organizations write in response to a proposal included in the Fiscal Year (FY) 2021 Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) proposed rule. In this rule, the Centers for Medicare and Medicaid Services (CMS) proposes to amend regulations to allow the use of non-physician practitioners (NPPs) to perform the IRF services and documentation requirements currently required to be performed by rehabilitation physicians under 42 CFR § 412.622. As representatives of the patients who require high-quality IRF-level care, as well as the clinicians and institutions that furnish services to the broader Medicare population, the undersigned organizations write to express our concerns that this proposal will undermine delivery of and access to physician-led team-based care in the IRF setting, which is critical for both ensuring the health and safety of patients receiving specialized rehabilitation care and differentiating the services that IRFs provide. We also are concerned that this sets a dangerous precedent for removing physician supervision requirements across all health care settings. For the reasons we further outline below, we strongly oppose this proposal to expand the scope of services NPPs furnish in IRFs, and we urge CMS to uphold the role of the rehabilitation physician in delivering and overseeing care for patients in IRF settings.

Rehabilitation physicians are leaders of the interdisciplinary care teams¹ that provide comprehensive medical and rehabilitative care to high acuity patients with chronic illnesses or disabilities, and/or who are in recovery from devastating physical traumas – that is, those who comprise the typical patient population in IRFs. Rehabilitation physicians lead the interdisciplinary rehabilitation team that optimizes patients’ medical and functional status. This is necessary for the patient population typical to IRFs who are extraordinarily vulnerable, complicated, and require comprehensive and multilayered care.

Relying on physician leadership – including in the IRF setting – is the most effective approach to maximizing the unique and complementary skill sets of all health care professionals on the team to

¹ The interdisciplinary rehabilitation team typically includes rehabilitation physicians, consultant physicians, nursing staff, therapists, neuropsychologists, social workers, as well as NPPs and others.
help patients achieve their care goals. While we recognize and appreciate the role that NPPs, such as nurse practitioners and physician assistants, play in providing care to IRF patients as part of an interdisciplinary care team, **NPPs’ skill set is not interchangeable with that of fully-trained rehabilitation physicians.**

To appropriately manage patient care and meet the current IRF coverage requirements, rehabilitation physicians are currently responsible for:

- evaluating and managing patients’ conditions, not only with respect to medical status but also to functional status, as well as assessing changes in status and adjusting treatment consistent with patients’ goals of care;
  - managing medication changes that must be made to accommodate exercise, including anti-hypertensive and diabetic medications;
  - managing the use of psychoactive medications including anxiolytics and anti-depressants;
  - managing complex care for high-acuity patients that includes medical management of:
    - changes in neurological status that may warrant imaging or transfer to an alternative level of care,
    - cardiovascular changes that occur with exercise, and
    - neurogenic bowel and bladder management,
  - coordinating pain management interventions;
- reviewing and concurring with findings of a comprehensive preadmission screening, which requires medical knowledge of the patient’s principal diagnosis in conjunction with their co-morbidities and biopsychosocial factors to determine prognosis for recovery;
- prescribing durable medical equipment;
- engaging in complex medical decision-making; and
- advocating for the many unforeseen needs newly disabled patients may have.2

In addition, IRF patients require rehabilitation physicians to manage devastating chronic issues resulting from spinal cord injuries, traumatic brain injuries, and a number of other illnesses and disabilities. Such complex patients have multiple co-morbidities that need to be managed concurrently. Most recently, rehabilitation physicians have been called upon to manage COVID-19 positive patients due to their unique experience in exercise and rehabilitation for patients who have cardiopulmonary instability.

To gain the expertise required to complete these activities, the rehabilitation physician develops a skill set through several avenues, including extensive medical education, residency, and often fellowship training and board certification; direct patient care experience in inpatient rehabilitation settings; and mentoring by physicians who offer guidance and share important lessons from their own experiences. Together, these provide rehabilitation physicians with a unique set of tools to use in treating IRF patients. Indeed, many physicians spend over 11 years in their undergraduate education and medical training and garner more than 10,000 hours of clinical experience in order to ensure they

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2 This list encapsulates just some of the responsibilities required to ensure IRF patients are appropriately managed. For a full list of the CMS coverage requirements of a rehabilitation physician, please see 42 CFR § 412.622.
are properly trained and educated to diagnose and treat patients. In addition, many rehabilitation physicians complete training to achieve board certification, with some completing additional years of subspecialty board requirements in Spinal Cord Injury Medicine, Brain Injury Medicine, and Neuromuscular Medicine and at least one year in medical management of patients in IRFs. By sharp contrast, the education and training of NPPs is significantly less. For example, nurse practitioners must complete only 2-3 years of graduate level education and 500-720 hours of clinical training. Physician assistant programs are two-years in length and require 2,000 hours of clinical care. The level of acumen obtained by physicians throughout their extensive education and training is simply not comparable to the education and training of nurse practitioners or physician assistants. Given the highly complex needs of the patient population in IRFs, the more extensive education and training of physicians equips them to lead the health care team responsible for these patients.

Furthermore, we believe that CMS’ proposal could reduce the standard and quality of care IRF patients receive. Rehabilitation physicians are the most highly educated and trained health care professionals within IRFs and should be maintained as the authorized leaders of the health care team. Allowing NPPs with comparatively less education, training, and experience to take on rehabilitation physician responsibilities, increases the risk of significant, problematic unintended consequences for IRF patients. Such action threatens the health and safety of this uniquely complex patient population and could result in inappropriate care plans, poor or sub-optimal patient outcomes, and inappropriate and unnecessary use of limited resources, potentially including inappropriate admissions, prolonged delivery of high-cost services, high-cost complications of mismanaged co-occurring conditions, and inappropriate and unnecessary use of equipment and supplies. We strongly disagree that the potential cost savings estimated by CMS and purported reductions in burden outweigh these risks. Indeed, we are concerned that the risks to patient care outlined above may even contribute to increased health care costs, rather than savings.

Finally, while we understand and concur with CMS’ desire to increase access to post-acute care services in rural areas, we do not believe services led by NPPs will rise to the level of services that IRFs are designed and paid to provide. To the contrary, in cases where NPPs are allowed to independently complete IRF coverage requirements currently completed by rehabilitation physicians, we believe there could be meaningful risk that patients would not be receiving IRF-level care. Patients for whom IRF-level care is appropriate require the specialized training and expertise of rehabilitation physicians to manage their care. We believe it is this critical element of specialized physician leadership that differentiates IRFs from other settings. We are concerned, therefore, that the CMS proposal would compromise the value proposition that IRFs offer. Not only would this lead to payments that do not align with the care that IRFs furnish, but – at a time when policymakers are considering major reforms to post-acute care including unified payment proposals – it could also place at risk the future viability and availability of traditional IRF care. These facilities would simply no longer be IRFs if NPPs replaced rehabilitation physicians, because they could not meet the needs of the highly complex patients that are increasingly in IRFs. Furthermore, we question whether CMS’ policy will achieve its stated goal of increasing access in rural areas. In reviewing the actual practice locations of NPPs, such as nurse practitioners, it is clear that nurse practitioners tend to work in the same areas as physicians, including in large urban areas, regardless of the level of autonomy they are granted at the state level, harboring sincere doubts that this proposal would have a significant, positive impact on access to care.
For the reasons outlined above, we urge CMS not to finalize its proposals to expand the scope of services NPPs furnish in IRF settings. Please feel free to contact Melanie Dolak, Associate Executive Director, Health Policy and Practice Services, American Academy of Physical Medicine and Rehabilitation, at (847) 737-6020 or mdolak@aapmr.org. Thank you for your consideration of our comments.

Sincerely,

American Medical Association
American Academy of Physical Medicine and Rehabilitation
American Academy of Dermatology
American Academy of Dermatology Association
American Academy of Family Physicians
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Otolaryngology-Head and Neck Surgery
American Academy of Pain Medicine
American Academy of Pediatrics
American Association for Hand Surgery
American Association for Physician Leadership
American Association of Clinical Urologists
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American Board of Physical Medicine and Rehabilitation
American College of Emergency Physicians
American College of Medical Genetics and Genomics
American College of Osteopathic Surgeons
American College of Radiation Oncology
American College of Radiology
American Congress of Rehabilitation Medicine
American Orthopaedic Foot & Ankle Society
American Osteopathic Association
American Psychiatric Association
American Society for Clinical Pathology
American Society for Dermatologic Surgery Association
American Society for Metabolic & Bariatric Surgery
American Association of Child and Adolescent Psychiatry
American Society of Anesthesiologists
American Society of Interventional Pain Physicians
American Society of Nephrology
American Society of Plastic Surgeons
American Spinal Injury Association
American Urological Association
Association of Academic Physiatrists
June 16, 2020

Dennis L. White, MSIT, DHA
President and CEO
Alliant Health Solutions
1455 Lincoln Parkway, Suite 800
Atlanta, Georgia 30346

Re: Letter of Support - TORP 190630 Clinician Quality Improvement Contractor (CQIC) Clinician-Focused Task Order

Dear Mr. White,

Please accept this letter of support from Missouri State Medical Association as our commitment to participate with Alliant Health Solutions, Inc. (Alliant), to support the Centers for Medicare & Medicaid Services (CMS) Center for Clinical Standards and Quality (CCSQ) for the TORP 190630 Clinician Quality Improvement Contractor (CQIC), or CMS National Quality Improvement and Innovation Contractor (NQIIC) Task Order 2, to support clinicians nationally.

We will ensure sustainability by participating with our Health Information Exchange SHINE to assist with data aggregation and quality measure calculation in Missouri with Alliant to provide support to community-based primary and specialty ambulatory care clinicians in quality improvement projects. We anticipate that we can contribute to the CMS goals of reaching those clinicians designated as needing assistance in our state.

If we can provide you with any additional information regarding our support and enthusiasm for this project and our willingness to help, please don't hesitate to contact us.

Best Regards,

Patrick Mills
Executive Vice President

cc: Russell Calicutt
June 17, 2020

The Honorable Nancy Pelosi
Speaker of the House of Representatives
U.S. Capitol Building, H-222
Washington, DC 20515

The Honorable Mitch McConnell
Senate Majority Leader
U.S. Capitol Building, S-230
Washington, DC 20510

The Honorable Kevin McCarthy
House Republican Leader
U.S. Capitol Building, H-204
Washington, DC 20515

The Honorable Charles Schumer
Senate Democratic Leader
U.S. Capitol Building, S-221
Washington, DC 20510

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

The undersigned state, specialty, and national medical associations collectively employ thousands of employees and represent hundreds of thousands of physician members across the country. We greatly appreciate the actions taken by Congress to help physicians on the frontlines of patient care meet the demands of the COVID-19 pandemic. This includes passage of the CARES Act and the Paycheck Protection Program and Health Care Enhancement Act, which established and provided supplemental funding for the Paycheck Protection Program (PPP). These Acts have helped many physician practices and other small businesses, including 501(c)(3) nonprofit organizations, cover payroll and other expenses during a period of severe loss in revenue caused by the COVID-19 public health emergency. We join with thousands of other professional and trade associations throughout the country in urging Congress to extend eligibility for the PPP loan program to include Internal Revenue Code section 501(c)(6) nonprofit organizations in the final version of the next COVID-19 aid package.

The CARES Act limited the types of nonprofit organizations that are eligible for a PPP loan to 501(c)(3) organizations. This means that other 501(c) nonprofit organizations, such as 501(c)(6) professional associations, cannot access the same PPP loans—or the favorable features of such loans, such as forgiveness—as other small businesses. However, many 501(c)(6) organizations are small businesses, and the COVID-19 public health emergency has had the same devastating impact on their business operations and ability to retain employees as other small businesses. For example, many medical professional associations generate a significant portion of their revenue by holding conferences and providing essential continuing medical education sessions that help maintain and improve quality patient care. Because the COVID-19 public health emergency has caused these conferences to be cancelled, many professional associations are facing severe financial losses and are in urgent need of financial assistance to remain in business. This could lead to the reduction in other services that benefit patients and are essential to maintaining a strong physician workforce, such as programs that improve the quality and efficiency of physician practices, improve physician satisfaction and wellbeing, or provide a pathway for clinical reentry following a life event such as raising a family.

501(c)(6) nonprofit organizations not only contribute significantly to the economy, they employ staff that are dedicated to improving the quality of the professional membership or trade they represent. We thank you for your consideration.

Sincerely,

American Medical Association
Honorable Nancy Pelosi
Honorable Kevin McCarthy
Honorable Mitch McConnell
Honorable Charles Schumer
June 17, 2020
Page 2

America Academy of Otolaryngic Allergy
American Academy of Cosmetic Surgery
American Academy of Dermatology Association
American Academy of Emergency Medicine
American Academy of Facial Plastic & Reconstructive Surgery
American Academy of Ophthalmology
American Academy of Pediatrics
American Academy of Sleep Medicine
American Association for Hand Surgery
American Association for Physician Leadership
American Association of Child & Adolescent Psychiatry
American Association of Clinical Urologists
American Association of Medical Society Executives
American Association of Neurological Surgeons
American College of Emergency Physicians
American College of Medical Genetics and Genomics
American College of Obstetricians and Gynecologists
American College of Osteopathic Surgeons
American College of Physicians
American College of Radiology
American College of Rheumatology
American College of Surgeons
American Geriatrics Society
American Medical Group Association
American Osteopathic Association
American Psychiatric Association
American Society for Aesthetic Plastic Surgery
American Society for Clinical Pathology
American Society for Dermatologic Surgery Association
American Society for Metabolic and Bariatric Surgery
American Society for Radiation Oncology
American Society for Reproductive Medicine
American Society for Surgery of the Hand
American Society of Anesthesiologists
American Society of Breast Surgeons
American Society of Cataract and Refractive Surgery
American Society of Dermatopathology
American Society of Echocardiography
American Society of General Surgeons
American Society of Hematology
American Society of Neuroradiology
American Society of Plastic Surgeons
American Thoracic Society
American Urological Association
College of American Pathologists
June 24, 2020

Richard Stone, MD
Executive in Charge
Veterans Health Administration
U.S. Department of Veterans Affairs
810 Vermont Avenue NW, Room 1063B
Washington, DC 20420

Dear Dr. Stone:

The undersigned medical associations and medical specialty societies are writing to register serious concerns with the Health Care Professional Practice in VA Memorandum (Memorandum) issued by the Office of the Under Secretary of Health on April 21, 2020, and underlying Directive 1899 (Directive). The undersigned organizations urge the Secretary to amend Directive 1899 as it relates to allowing non-physician healthcare professionals in 32 specialties to operate “within the full scope of their license, registration, or certification” and rescind the Memorandum as it relates to encouraging all VA medical facilities to allow CRNAs to practice without physician oversight during the national health emergency.

The undersigned organizations are very concerned Directive 1899 preempts state scope of practice laws. Directive 1899 memorializes U.S. Department of Veterans Affairs (VA) policy allowing VA health care professionals to practice across state lines and establishes new policy allowing VA health care professionals to operate within the full scope of their license, registration, or certification. This combination in effect circumvents state scope of practice laws for the 32 health care professionals defined in the directive. Such a far-reaching expansion is overly broad, unnecessary and threatens the health and safety of patients within the VA system. As state scope of practice laws vary across these professions and across states, we urge the Secretary to amend the directive to defer to state scope of practice laws, similar to the language related to psychologists in Appendix B of the Directive.

The undersigned organizations also encourage the Secretary to rescind the Memorandum as it relates to encouraging all VA medical facilities to allow CRNAs to practice without physician oversight during the national health emergency. Throughout the coronavirus pandemic physicians, nurses, and the entire health care community have been working side-by-side caring for patients and saving lives. The AMA supports these temporary emergency efforts that allow physicians to practice across state lines to quickly expand the physician workforce in areas of need. Our success as a nation in flattening the curve of this pandemic is due in no small part to this shared focus and shared responsibility. Now more than ever, we need health care professionals working together as part of physician-led health care teams—not in silos. Therefore, it is deeply troubling, that the VA is directing all VA medical facilities to amend their by-laws to allow CRNAs to practice without physician oversight.
Like most healthcare systems, the pandemic has forced the VA to reassess how it uses human resources. Non-essential surgeries have been cancelled during the pandemic, giving the VA flexibility to deploy physicians and other healthcare professionals where the need is greatest. As such, there are more than enough physicians to provide care and oversight during this time. Thus, removing physician oversight requirements of CRNAs at the VA is overly broad, inconsistent with the situation as it is unfolding outside of the VA, and unnecessary to address the immediate needs raised during the COVID-19 pandemic. This action by the VA will only serve to disrupt continuity of care and cause confusion among health care teams and their patients.

It was this knowledge that prompted West Virginia Governor James C. Justice, II to promptly issue Executive Order No. 12-20, on March 26, 2020, reinstating physician supervision of CRNAs during the public health emergency. As such, it is unclear why the VA has deemed the expansion at issue as necessary. Such measures are not necessary to improve patient access to care and take away from a higher quality team-based approach. More importantly, a lack of proper oversight threatens the health and safety of veterans and their families.

For all the reasons outlined above, the undersigned organizations strongly urge you to amend Directive 1899 and rescind the Memorandum. Such broad expansions of scope of practice deserve thoughtful discourse where all sides are allowed to be heard and all available evidence is considered. Thank you in advance for your attention to this important matter.

Sincerely,

American Medical Association
AMDA - The Society for Post-Acute and Long-Term Care Medicine
American Academy of Dermatology Association
American Academy of Emergency Medicine
American Academy of Physical Medicine and Rehabilitation
American Association for Hand Surgery
American Association of Hip and Knee Surgeons
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Emergency Physicians
American College of Medical Genetics and Genomics
American College of Osteopathic Surgeons
American College of Radiology
American Medical Women’s Association
American Orthopaedic Foot & Ankle Society
American Osteopathic Association
American Psychiatric Association
American Society for Clinical Pathology

1 Despite this, West Virginia has been incorrectly included on the VA list of states that have temporarily suspended licensure limitations for CRNAs.
June 29, 2020

The Honorable Senator Roy Blunt
The Honorable Senator Joshua Hawley
The Honorable Representative Ann Wagner
The Honorable Representative Emanuel Cleaver II
The Honorable Representative Billy Long
The Honorable Representative Jason Smith
The Honorable Representative Lacy Clay, Jr.
The Honorable Representative Blaine Luetkemeyer
The Honorable Representative Sam Graves
The Honorable Representative Vicky Hartzler

Delivered via email

Re: Support for the Physician Access Reauthorization Act

Dear Senators and Representatives of the Missouri Congressional delegation,

On behalf of the Missouri State Medical Association and physician members across the state, we are writing in support of legislation to increase access to care and promote the ability of International Medical Graduates to practice medicine in our communities. We urge your support for the Physician Access Reauthorization Act (S.948/H.R. 2895).

International Medical Graduates (IMGs) are vital members of the U.S. physician community, providing quality care to patients – often in underserved communities and to vulnerable populations. More IMGs means that the U.S. can increase its response efforts and prepare for future demands that may be placed on our health care system.

We all know that the U.S. is facing a severe physician workforce shortage – current projections indicate that there will be a shortfall of nearly 122,000 physicians by 2032 – but some areas of our state and our country are particularly medically underserved. Missouri ranks third in Health Professional Shortage Areas (HPSAs) behind California and Texas. The Physician Access Reauthorization Act would reauthorize the Conrad 30 Waiver Program, which enables resident physicians from other countries that are working in the U.S. on J-1 visas to remain in the U.S. if they agree to practice in a medically underserved area for three years. We urge you to support these bills.

Thank you for your consideration and your continued efforts to maintain the health and well-being of our state's residents. If you have questions or if we can be of assistance to your office in any way, please do not hesitate to let us know.

Sincerely,

Patrick Mills
Executive Vice President
June 22, 2020

Katie Clay  
Director Student Financial Aid-Enrollment Services  
A.T. Still University  
800 West Jefferson  
Kirkville, MO 63501

Dear Ms. Clay:

The Missouri State Medical Association will be awarding its annual MSMA Scholarships funded by the Missouri State Medical Foundation. This year’s $45,000 award for the 2020-21 school year is enclosed.

At this time, we would like to enlist your assistance in identifying ten medical school students from A.T. Still University School of Medicine to receive an MSMA Scholarship in the amount of $4,500 each.

Please incorporate the following criteria in the selection process:
- Missouri high school graduate,
- Second year of medical school,
- MSMA student member, and
- In need of financial aid.

Please let me know when you have identified the medical students and I can assist in verifying MSMA medical student membership. We would also like to publish a picture of the medical students in our newsletter and encourage you to publish the picture in your medical school alumni news as well. Please email your picture to jhowell@msma.org.

Thank you again for your assistance in providing us with this opportunity. Please call if you have any questions.

Sincerely,

Jeff Howell  
General Counsel