



June 11, 2020

Scott P. Serota
President and CEO
Blue Cross Blue Shield Association
1310 G St. NW
Washington, DC 20005

Dear Mr. Serota,

On behalf of the American College of Physicians (ACP), the largest medical specialty organization and the second largest physician group in the United States, I am writing to share ACP's recommendations to the Blue Cross Blue Shield (BCBS) Association and its network of independent and locally operated BCBS companies regarding telehealth and regulatory flexibilities that will need to remain in place for an extended period after the Coronavirus Disease 2019 (COVID-19) national public health emergency (PHE) has lifted. ACP members include 159,000 internal medicine physicians (internists), specialists, and medical students dedicated to scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

Since our [last letter](#), we have appreciated BCBS' leadership and how its member plans have stepped up to ease burdens on clinicians and expand reimbursement for telehealth and telephone services so that physicians can safely treat their patients while preventing the spread of COVID-19. In particular, we appreciate plans offering expanded telehealth offerings, temporarily waiving cost sharing for telehealth services, and waiving prior authorization for testing and medically necessary services for COVID-19 patients. These important policy changes will allow for increased access to and use of telehealth functionality and virtual care have played a pivotal role in mitigating the effects of the COVID-19 pandemic.

However, these flexibilities are not being employed consistently across all BCBS plans. After battling this crisis for several months, many practices are stretched to their financial and resource limits and are struggling to keep their doors open due to an unprecedented drop in patient volume and revenue.¹ Practices need additional support, particularly financial support.

Specifically, the College is calling for immediate:

- 1) Full payment parity for all telehealth services and audio-only services relative to in-person E/M visits by all insurers;
- 2) Compensation to counteract the unparalleled drop in revenue including reimbursing waived patient copays and instituting direct relief payments;
- 3) Development of Alternative Payment Models that move away from inconsistent fee-for-service (FFS), particularly those that offer fixed, periodic prospective payments; and
- 4) Relief from burdensome coding and documentation requirements including prior authorization requirements.

¹ "National Income and Product Accounts: Table 1.5.1 Percent Change From Preceding Period in Real Gross Domestic Product, Expanded Detail." Bureau of Economic Analysis. Last revised May 28, 2020:
https://apps.bea.gov/iTable/iTable.cfm?reqid=19&step=3&isuri=1&nipa_table_list=31&categories=survey.

Despite financial support from federal and state governments, at the end of May 45% of practices reported staff furloughs or layoffs, 28% reported deferred salaries, and 14% had temporarily closed, inhibiting patient access to care.² According to a new report from FAIR Health, from April 2019 to April 2020, utilization of professional services fell 68% and revenue is down 48%.³ If private payers do not join with the Centers for Medicare & Medicaid Services (CMS) to provide physician practices with the critical support they need in this unprecedented crisis, hundreds if not thousands of practices across the country may be at real financial risk of closing, leaving a critical shortage of healthcare services at a time we can least afford it.

I. Telehealth and Remote Patient Monitoring Services (RPM)

The steps undertaken by BCBS member plans to address the need for telehealth solutions during this pandemic are welcome and necessary to allowing patients to continue receiving critical medical services while ensuring their own personal safety and preventing further spread of COVID-19. ACP appreciates all 36 independently operated BCBS companies and the BCBS Federal Employee Program (FEP) expanding telehealth service offerings for 90 days. **More information is needed on the specific terms and limitations of these expanded telehealth services, including how they vary across BCBS plans.** For example, in many cases, coverage is limited to certain medical services or in-network clinicians, which have become increasingly narrow and in some cases, consolidated under the payer's direct ownership.⁴ It is also unclear whether BCBS will cover new patients, as well as established patients, as CMS has done. It is also common for telehealth coverage to exclude audio-only services, which is a problem when nearly three in ten patients do not have access to broadband to support most digital care platforms,⁵ or limit telehealth services to certain propriety platforms, such as LiveHealth Online. This is extremely problematic, as some of these approaches do not allow patients to interact with their own personal clinicians, thus interfering with ongoing patient-physician relationships and leading to fragmented care. These relationships are the underpinning of continuous and coordinated care, particularly for patients with multiple chronic conditions who most need to socially distance from physician practice settings—and in some cases, from their own family members—to protect themselves from exposure to the virus while receiving uninterrupted care services. Finally, ACP commends BCBS Massachusetts for reimbursing telehealth visits at the same rate as in-person visits during the COVID-19 PHE. Unfortunately, full payment parity is the exception and not the norm, particularly when it comes to audio-only services.

ACP urges BCBS to call on its plans to adopt a uniform policy that reimburses all telehealth and audio-only services on par with in-person services for both new and established patients. Practices are struggling to keep their doors open during this pandemic; time spent monitoring for updates on individual payer policies is time that could be devoted to direct patient care or slowing the spread of the disease. **ACP further calls on BCBS plans to allow use of public facing video platforms such as Skype and FaceTime to provide patients and physicians with more options to ensure effective and efficient virtual care during, and ideally beyond, the PHE.** To ensure continuity of care, telehealth and telephone services must be available through readily accessible technologies to patients and their clinicians, not proprietary insurer platforms.

² Primary Care & COVID-19: Week 11 Surveys. Primary Care Collaborative. May 27, 2020.

<https://www.pcpc.org/2020/05/26/primary-care-covid-19-week-11-surveys>.

³ Healthcare Professionals and the Impact of COVID-19. A Comparative Study of Revenue and Utilization. June 10, 2020.

<https://s3.amazonaws.com/media2.fairhealth.org/brief/asset/HealthcareProfessionalsandtheImpactofCOVID-19-ComparativeStudyofRevenueandUtilization-FAIRHealthBrief.pdf>.

⁴ Weigel G, Ramaswamy A, Sobel L, et al. "Opportunities and Barriers for Telemedicine in the U.S. During the COVID-19 Emergency and Beyond." Kaiser Family Foundation. Published May 11, 2020: <https://www.kff.org/womens-health-policy/issue-brief/opportunities-and-barriers-for-telemedicine-in-the-u-s-during-the-covid-19-emergency-and-beyond/>.

⁵ Primary Care & COVID-19: Week 11 Surveys. Primary Care Collaborative. May 27, 2020.

<https://www.pcpc.org/2020/05/26/primary-care-covid-19-week-11-surveys>.

Patient access to RPM services also is critically important in order to maintain patient safety and slow the spread of COVID-19. ACP [applauded](#) CMS' [recent decision](#) to expand access to RPM services by allowing physicians to bill them for both new and established patients, as well as acute and chronic conditions, and to allow patients to consent to these services once annually. **We implore BCBS plans to emulate these recently finalized CMS flexibilities for RPM services.**

Finally, as discussed earlier, practices have made significant adjustments to their delivery structure in light of the crisis, including investing in and shifting to an infrastructure that is much more dependent on telehealth and audio-only visits, as well as RPM services. To reverse these policies and revert to a reimbursement structure that centers on in-person services is not an effective way to recover from this crisis, nor to prepare for future potential outbreaks. Therefore, **ACP urges BCBS to consider making many of these changes permanent. At a minimum, these changes should extend at least through the end of 2021, or until such a time when effective vaccines and treatments are widely available, with an option to extend further based on the experiences of patients and physicians.**

II. Patient Cost Sharing

ACP appreciates that all BCBS plans have offered patients critical relief from copays and cost sharing for certain telehealth services for 90 days and services related to testing and treatment for COVID-19 through May 31. At a time when the country is facing the highest unemployment rate since the Great Depression,⁶ these policies are critical to getting patients the treatment they need and preventing further spread of the disease. Unfortunately, the majority of plans are not making up the difference to practices, leaving them to absorb another 20% loss when they are already facing revenue shortfalls of 55% in many cases.⁷ Policies are also inconsistent across BCBS plans, with variation in what types of plans and patients are covered. While BCBS Michigan has agreed to waive copays for in-network primary care and behavioral health services, this is not the case with many BCBS plans. Many cost sharing support policies are restricted only to patients formally diagnosed with COVID-19, despite the well-established under-reporting of cases,⁸ or in the case of telehealth services, those furnished by proprietary technology platforms. Others apply to in-network clinicians, which can be dangerous during a public health crisis, particularly in areas where networks are narrow or access is otherwise limited. **ACP calls on all BCBS plans to establish consistent policies that allow clinicians to waive patient cost sharing for COVID-19-related testing and treatment, primary care visits, and all telehealth and telephone services. Importantly, plans should also pay the difference for all waived patient cost sharing to protect practices from further revenue losses. These policies should last at least through the end of 2021, with an option to extend further as needed to ensure continued beneficiary access to care.**

III. Direct Relief Payments

ACP commends the BCBS network of plans for rising to the occasion and committing nearly \$3 billion to patients, communities, and physician care teams in support of the ongoing fight against COVID-19, including personal protective equipment for frontline clinicians. This critical support will help communities and practices to curb spread of the disease and rebuild faster. Despite these important supports, ACP has heard from many internal medicine specialists providing primary and comprehensive care to patients that they are just weeks away from closing their doors due to drastic declines in patient volume and therefore revenue. Only 47% of

⁶ "The Employment Situation: April 2020." Bureau of Labor Statistics, U.S. Department of Labor. Published May 8, 2020: <https://www.bls.gov/news.release/pdf/empsit.pdf>.

⁷ "COVID-19 Financial Impact on Medical Practices." Medical Group Management Association. Published April 8, 2020: <https://www.mgma.com/getattachment/COVID-Financial-Impact-One-Page.pdf>.

⁸ "Excess Deaths Associated with COVID-19." National Center for Health Statistics, Centers for Disease Control and Prevention. Last revised May 27, 2020: https://www.cdc.gov/nchs/nvss/vsrr/covid19/excess_deaths.htm.

practices report having enough cash on hand to stay open four more weeks.⁹ Even as in-office visits begin to resume, we anticipate that reduced patient volumes and associated revenue losses will continue through the end of 2021 at a minimum. COVID-19 mitigation strategies will require that clinicians continue to space out in-person appointments and see fewer patients per day. Many patients will be reluctant to come into the office for care. While telehealth payment parity policies help to cover some of this shortfall, they do not begin to cover the full scope of losses.

We recognize and appreciate that the U.S. Department of Health and Human Services (HHS) made general distributions to physicians and hospitals out of the Provider Relief Fund (PRF) created by the Coronavirus Aid, Relief, and Economic Security (CARES) Act and that Congress provided an additional \$75 billion in funding for hospitals and physicians through the Paycheck Protection Program and Health Care Enhancement Act. However, such disbursements are not sufficient to keep many practices from closing. The general allocations also require that primary care and internal medicine subspecialists, including those in small independent practices, compete for limited funding with much larger hospital or health systems and often come up short, leaving many primary care needs unmet. For practices to survive financially, private payers must do their part.

ACP calls on BCBS plans to make their own direct relief payments to primary care physician practices, internal medicine subspecialty practices, small practices, and practices serving underserved communities, retroactive to April 1 through the end of the calendar year. The College makes this ask of the private payers in parallel with our [ask](#) to HHS to establish a targeted allocation out of the PRF to primary care physician practices, similar to the targeted allocation for rural hospitals, that is sufficient to offset at least 80% of total lost revenue from all public and private payers for the same timeframe. Allocation amounts would take into account disbursements already received by such practices from the general PRF allocations. **Private payers should work with Medicare and Medicaid to ensure that together they provide the necessary support practices need to keep their doors open, rather than being forced to close or sell to equity firms or large consolidated health care systems, which will ultimately drive up health care costs and reduce patient access to care.**

IV. Value-Based Payment Opportunities

The existing cracks of the FFS infrastructure have become exacerbated and exposed by the pressures of dealing with COVID-19 crisis.¹⁰ FFS has proven to be an ineffective infrastructure for effectively delivering population-level health, particularly in times of crises. Practices face severe revenue shortfalls due to an unprecedented drop in patient volumes at the very time they most need additional financial resources to rapidly build up a new infrastructure to effectively treat the influx of COVID-19 patients, along with their regular patients, while preventing further spread of the disease. This crisis has underscored the urgency with which innovative value-based alternatives must be developed. **ACP urges BCBS plans to create more opportunities for primary care and internal medicine specialty physician practices to transition away from FFS by expanding existing or expediting the development of new alternative payment arrangements. In particular, payers should look to develop models that offer fixed, periodic prospective payments such as PMPM payments that will give healthcare systems the financial consistency needed to build the necessary population management infrastructure to more effectively deal with future health crises.** Importantly, these new financial models should provide both up-front funding and reinsurance options and offer clinicians a variety of financial risk levels including low to no risk options, particularly in the near term as practices recover from the financial and infrastructure shock of dealing with this crisis. ACP also commends BCBS Massachusetts

⁹ "Primary Care & COVID-19: Week 5 Survey." Primary Care Collaborative. Published April 17, 2020: <https://www.pcpc.org/2020/04/16/primary-care-covid-19-week-5-survey>.

¹⁰ "Primary Care & COVID-19: Week 3 Survey." Primary Care Collaborative. Published April 1, 2020: <https://www.pcpc.org/2020/04/01/primary-care-covid-19-week-3-survey>.

for accelerating payments under its Alternative Quality Contract and BCBS Michigan for offering accelerated funding for its Physician Group Incentive Program. The College encourages all BCBS plans to make performance-based funds available as soon as possible.

Equally important, clinicians who are currently participating in existing value-based arrangements must be assured they will not be penalized for adverse quality or utilization outcomes that directly result from the COVID-19 PHE. Not doing so risks undercutting clinician willingness to participate in future value-based payment reforms and subjects practices to further payment cuts they cannot afford based on compromised data. **BCBS plans should not use 2020 data as a basis for assessing performance-based penalties or making network determinations.** Additionally, BCBS plans should agree not to post 2020 quality and cost data for public consumption and not use this data to inform measure thresholds, financial benchmarks, risk adjustment, or patient attribution for future performance years, given the largescale impact of COVID-19.

V. Relief from Administrative Burden

ACP appreciates the steps jointly taken by all independently owned plans and the FEP to curb administrative burden during this critical time, particularly waiving prior authorizations for testing and medically necessary services for COVID-19 patients. ACP commends individual BCBS plans who have gone further, such as BCBS Massachusetts, which has agreed to remove prior authorization requirements and move to notification-only requirements for certain post-acute care facilities. These changes will help to expedite treatment of COVID-19 patients and free up medical resources and staff to treat more urgent cases. However, BCBS plans should expand these policies to all patients, not just those formally diagnosed with COVID-19. Many COVID-19 cases go unreported, which means a large number of patients and services will be subject to wait times during critical windows that puts the patient's own health in jeopardy, as well as those around them. Additionally, satisfying prior authorization requests places a major strain on practice resources and staff time, both of which are in critical supply during the COVID-19 PHE. On average, medical practices spend two days per week per physician on prior authorization requests.¹¹ Providing even temporarily relief from burdensome prior authorization and other documentation requirements for not just COVID-19 patients but all patients during this critical time could allow physicians to devote more of their limited time and resources toward treating patients and stopping the spread of COVID-19. Moreover, patients are avoiding non-urgent in-person services to limit their risk of exposure, so the risk of lifting these requirements during the PHE is low. **ACP calls on all BCBS plans to waive prior authorization requirements and ease documentation requirements for all patients (not just COVID-19 patients) for the duration of the COVID-19 PHE and immediate recovery period, at least through 2021 or until such a time when effective vaccines and treatments are widely available, with an option to extend further or make permanent based on learned experience.** ACP also reiterates its [previous recommendations](#) to emulate recent finalized changes to Medicare clinician enrollment and credentialing and E/M coding so clinicians can rely on a uniform set of rules and guidelines during this crisis.

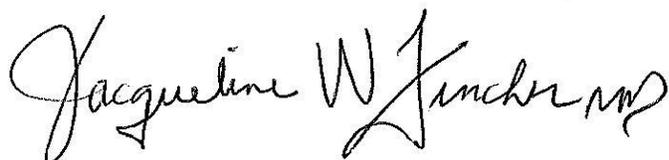
In Conclusion

ACP is encouraged by the actions taken by the BCBS Association and its network of affiliated plans to date that will enable physicians and their teams to safely treat COVID-19 patients and prevent further spread of the disease while continuing to care for the rest of their patients in a way that minimizes risk for everyone. At the same time, more can and needs to be done. Physician practices do not have the time to sort through the current patchwork of policies and various expiring deadlines. ACP is calling on the BCBS Association to serve as a leader during this time of crisis and call on its member plans to step up and provide struggling physician practices with the financial support and administrative relief they need to focus on treating patients and

¹¹ "2017 AMA Prior Authorization Physician Survey." American Medical Association. Published February 2018: <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc/prior-auth-2017.pdf>.

surviving this pandemic. This support must include reimbursing practices for waived patient copays and following CMS' lead to institute direct relief funds. The recovery will be gradual and take place over the course of several years, not days. It is critical that BCBS plans continue this support not just during the immediate PHE, but also over the full recovery period. As the untold impact of this pandemic continues to unfold, ACP would like to offer our full assistance as we continue to support medical practices through the immediate crisis and begin the rebuilding process. Please contact Suzanne Joy, Senior Associate, Regulatory Affairs, at 202-261-4553 or sjoy@acponline.org with questions or for additional information.

Sincerely,

A handwritten signature in black ink that reads "Jacqueline W. Fincher, MD, MACP". The signature is written in a cursive style with a large initial "J" and a distinct "W".

Jacqueline Fincher, MD, MACP
President
American College of Physicians