

Overview & Summary of September 2020 Physician-Focused Payment Model Technical Advisory Committee (PTAC) Public Meeting Discussions on Telehealth November 5, 2020

This report summarizes input that the Physician-Focused Payment Model Technical Advisory Committee (PTAC) received and provided during its public discussion on the topic of telehealth. The discussion provided current perspectives on the role telehealth can play in optimizing health care delivery and value-based transformation in the context of alternative payment models (APMs) and Physician-Focused Payment Models (PFPMs) and will serve to inform PTAC in its review of future physician-focused payment model proposals.

Background: The September 15-16, 2020 Public Meeting of PTAC included a theme-based discussion on telehealth in addition to the deliberation of specific proposals submitted to PTAC. This discussion informed the Committee on topics important to Physician-Focused Payment Models (PFPMs). The Telehealth discussion was designed to provide Committee members with current perspectives on the role telehealth can play in optimizing health care delivery and value-based transformation in the context of alternative payment models (APMs) and, specifically, PFPMs—serving to further inform its review of future proposals.

In response to the COVID-19 public health emergency (PHE), the Centers for Medicare & Medicaid Services (CMS) instituted several flexibilities in its regulations pertaining to telemedicine that have enabled an unprecedented increase in utilization of telehealth services. These changes are likely to have far-reaching impacts long after the PHE has passed. Thus, PTAC believed that the timing was optimal to investigate lessons learned from recent experiences pertaining to the use of telehealth and how they might inform policymaking as part of value based transformation. Within that context, PTAC believed that potential insights could be learned from the work of previous proposal submitters who included telehealth as a component of their proposed PFPMs, specifically. PTAC also believed that it would be important to consider the expertise of additional subject matter experts who could provide various perspectives on telehealth, as well as public comments from stakeholders.

The Telehealth session included an overview of 18 proposals submitted to PTAC as of March 2020 that included telehealth as a component of their models; a panel discussion with six of the previous PTAC proposal submitters regarding their insights; a panel discussion with seven subject matter experts (see Appendix A for a list of the individuals who participated in the two panel discussions); public comments from several stakeholders; and an additional discussion among Committee members. The following section summarizes key insights from the Telehealth session regarding telehealth based on its widespread use that occurred during the PHE. The remainder of the document summarizes additional themes relating to telehealth and APMs that emerged during the Telehealth session.

Key Insights Regarding the Use of Telehealth During the PHE:

- Complex regulations (relating to payment and other policies) were challenges that inhibited previous use of telehealth that, when relaxed, led to exponential increases in telehealth use, particularly for certain specialties, such as primary care.
- Providers already engaged in APMs were among those who were most able to adapt quickly to the use of virtual health care delivery to ensure continuity of care.
- Virtual health care delivery was shown to exhibit promise in ensuring access to care for many, and in particular individuals receiving behavioral health services. Virtual communications can serve as a tool to optimize care services across systems of care.
- Many panelists felt that it is important to use caution such that virtual health care does not exacerbate disparities in care among vulnerable populations who may not have access to or skills related to using the needed technologies.
- It is important to find the right balance between virtual and “hands-on” services to optimize care for individuals. Virtual services cannot fully substitute for hands-on care. Commenters were clear that telehealth should not become another care “silo” but instead should be part of fully integrated person-centered care.

Additionally, some of the past PTAC submitters whose proposals included a telehealth component indicated the following points based on their recent experience delivering health care during the PHE:

- Telehealth can be valuable as a frontline assessment tool for limiting the number of hospitalized patients and thus exposure to COVID-19 among vulnerable groups.
- The easing of geographic restrictions associated with payment for telehealth and inclusion of emergency medical screening as a covered telehealth service during the PHE have helped to preserve personal protective equipment, reduced exposure to COVID-19, and facilitated follow-ups after emergency department discharge.
- Despite the telehealth waivers, a barrier to timely care persists because patients with chronic conditions often accept symptoms as normal and do not seek care prior to requiring hospitalization. Such care avoidance may worsen during the PHE; this barrier may be lessened through remote symptom monitoring and proactive outreach rather than patient-initiated telehealth consults.
- The telehealth waivers do not adequately provide ongoing access to interdisciplinary providers (e.g., geriatricians and social workers) for patients and staff in skilled nursing facilities (SNFs). An APM would be needed to support a cultural shift from using telehealth as an “event” to part of routine care.
- It is difficult for providers to build workflows that accommodate some patients receiving telehealth consults and other patients receiving traditional care.
- Primary care and specialty providers undergoing a rapid switch to telehealth were required to develop a team approach that involved reviewing schedules, educating patients, conducting pre-telehealth visit technology testing, and creating backup plans to go to audio-only as needed. These providers have developed approaches to determining conditions when a patient must come for a physical visit.

Summary of Various Themes Discussed by Previous PFPM Proposal Submitters, Subject Matter Experts and Public Commenters During the Telehealth Session of the PTAC Public Meeting

General Topics on the Use of Telehealth and Ensuring Patient Access: The input from the panelists and public commenters offered real-time and expert evaluations on the use of telehealth, its promise and its risks. There was resounding consensus among the panelists that from their perspective, telehealth/telemedicine, often referred to as virtual health care, is a tool that can optimize care delivery and that it is here to stay in some capacity, along with in-person health care services. Telehealth can augment available services in a manner that can foster timely, integrated, coordinated, proactive care and patient monitoring, “...enabling the right care to the patient at the right time in the right modality as determined by the provider, including in-person care services.” Several panelists specifically noted that the relaxing of regulations surrounding important areas such as payment, location of services renders, licensure jurisdictions, etc. broke down perceived barriers that have inhibited telemedicine as a tool up until the onset of the current health crisis.

However, panelists also raised the importance of developing “guardrails,” that is, the inclusion of various protections with the use of telehealth—ranging from protections that would be designed to help prevent disparities in care, to protections for ensuring appropriate use of and payment for virtual services. Panelists offered potential solutions as well. Specifically, several panelists provided important perspectives indicating that strategic thought is needed regarding what the best payment mechanism

would be for virtual services, determining the true cost associated with virtual health care delivery, securing privacy protections, how virtual care is integrated with in-person visits, and the importance of developing quality and outcome-based monitoring programs and cultivating and instituting best practices. (See Appendix B for additional information about comments and recommendations made by participants in the Telehealth session). Additionally, subject matter experts already engaged in providing telehealth services noted that it requires: engagement in cultural change by providers and their staff; integration of the full spectrum of patient care providers (e.g. social workers, nurses, therapists); education of all stakeholders (including beneficiaries) on how to optimize its use; and monitoring for abuses. Panelists emphasized that while telehealth can serve to optimize health services, it cannot exist as the *only* approach, and it should be used with discretion.

Significantly, panelists from not only the patient advocacy and long-term care services perspective, but from nearly all subject matter expert views, noted the vulnerabilities that are inherent in the use of technology in providing health care services remotely. In particular, this concern was raised with regard to individuals who are most vulnerable to poor access to health care services. Some of the populations that were discussed included those that lack home-based support and are not technologically savvy, including: elderly persons and patients who are affected by the digital divide; those who live in rural areas and lack broadband capabilities; and those who possess language barriers or have visual, hearing or other disabilities that can make using virtual services impractical or worse yet, impossible. For these reasons, panelists drove home the critical point that while virtual care delivery can foster efficient, effective, high quality and timely care delivery, this modality also has the potential to *inhibit* access to high quality care, furthering disparate care among those who are most vulnerable and already experiencing barriers to prompt, coordinated, health care services.

Financial and Other Mechanisms that can Optimize the Use of Telehealth: Panelists agreed that relaxed regulations enabled providers to rapidly engage in the use of telehealth, and noted that providers already engaged in APMs were able to pivot more easily to the use of virtual care services as part of their coordinated care delivery system's suite of services. Compared to providers who were dependent upon fee for service (FFS) payment structures, providers engaged in APMs were among those most capable of financial resilience during the PHE, and best able to redirect care services to virtual modalities expeditiously and saliently in order to continue care delivery overall. Panelists noted the significance of predictable financing and shared that APMs can enable providers to plan investments in and integration of telehealth services in patient care more effectively than FFS payment.

Panelists emphasized that while billing complexity is a major barrier to telehealth for providers, value-based payment and APMs can help to overcome these challenges. During the PHE, value-based payment mechanisms helped providers to stay open and preserve patient access. Panelists also stressed that in looking forward, building in flexibility in payment approaches for telehealth services is critical, including the possibility of continued FFS payments as appropriate. Additionally, panelists engaged in APMs expressed that providers need several years of reimbursement and participation in models in order to sufficiently realize the investments that are made in telehealth and its services. A suggestion was also made that partnership across all stakeholders, be it payer, provider, employer or consumer, be established in order to work toward the same goals related to the most effective use of virtual care. Panelists also indicated that the benefits of investments in partnerships and integrated systems (including virtual care) would likely be realized over time.

Several subject matter experts noted that telehealth cannot exist in a silo, and that integrating telehealth and payment models should be considered across the health care system and structure. Subject matter experts providing a telehealth/informatics perspective emphasized that virtual care services necessitate costs beyond the “visit,” including efforts to engage the greater health care delivery team. Subject matter experts providing a patient advocacy perspective explained that *access* to appropriate virtual services is necessary to take into consideration with regard to costs. Examples of potential solutions included the use of audio-only visits, distribution and access to virtual devices, and in-home services and supports. However, they also noted that other issues exist that may be challenging to overcome, such as broadband issues, but that such challenges cannot be ignored.

Panelists also noted that in order to optimize the use of virtual telemedicine, providers and payers must take into account the costs and value of the competency and training needs of all members of the care team, including patients themselves. Other panelists raised the notion that providers and specialists in remote, rural areas must have access to the most current medical information. Panelists emphasized that virtual health care should be coupled with real-time access to expert consult, with ongoing consultation on the most current and novel therapies, treatments and interventions to ensure that care delivery keeps pace with science and medicine. Taken together, panelists suggested that ongoing training and education across the board are important for enabling optimal use of telehealth, telemedicine and telemonitoring; in particular, such modalities alone are insufficient without ongoing provider training.

Requirements to Meaningfully Expand Telehealth Through Delivery System Reform: Value-based purchasing and APMs helped providers remain open and accessible during the PHE, preserving patient access. Panelists suggested that mechanisms such as population-based payments can provide revenue stability for planning investments in and use of telehealth services. Such mechanisms also provide incentives for the cost-effective use of these services within integrated and coordinated care. However, lessons learned need to be applied, and a strategic, long-term outlook is important when creating policies related to telehealth as an attribute within the broader context of value-based transformation.

Overall, subject matter experts emphasized that the integration of telehealth should not perpetuate silos in health care; rather, telehealth should serve as a tool for care integration across the system of care. Policies, including payment-related initiatives, should enable flexible payment and delivery approaches to optimize health care delivery, even to include continued FFS. Panelists raised that such policies should take into account actual costs, and should necessarily incorporate costs associated with the availability of evidence-based science for providers (e.g. hub-spoke consortiums). Payment policies should consider the costs associated with staff training and team-based care, providing resources for patients, communications and outreach, and any other costs necessary to optimize telehealth as a tool in care delivery.

Panelists expressed that person-centered and patient-level resources and solutions are critically important in addressing the many obstacles that exist in the use of virtual technology, such as broadband-related barriers, disabilities, language or knowledge barriers, and other challenges. Such solutions are necessary in order to optimize the use of virtual technology aimed at enhancing health care delivery.

Further, overcoming such barriers, as well as others, such as ensuring data uniformity for health information exchange, may come with real costs and require efforts associated with expanding business operations and technical infrastructure. A panelist expressed that it's important to "unleash data" needed to understand the telehealth experience, integrate telehealth into existing APMs, use APMs (both new and existing) to directly address the digital divide, facilitate access to interdisciplinary teams, provide patient education, and support effective care navigation. Thus, models developed to test the use, efficacy and outcomes of telehealth via APMs should run for more than one or two years—they should be carried out over longer periods, including up to at least five years to evaluate the full extent of the investment.

Panelists suggested that whatever policies are enacted in the future, for both payment and oversight, should be simple—not overly burdensome and complicated—to avoid bringing patients and providers back to the same barriers that previously resulted in the low use of virtually-based services.

PTAC Member Insights: Committee members reflected on various points made by the panelists at the meeting's conclusion. Committee members indicated that in order to optimize the use of telehealth, partnerships across payers, providers and technology are needed along with best practices for ensuring their success. Other comments included that care delivery models that incorporate virtual access should align with patient preferences, and that while there may not be just one solution, there shouldn't be a plethora of models either. Other Committee members reflected on the importance of flexibility and simplicity, and that there are push-pull issues to be taken into consideration. Additionally, tactical challenges are wide and global, including payment, parity, interoperable information exchange, averting continued siloed systems, and, importantly, retaining patient-centered care delivery. Other Committee members reflected on the importance of alignment across many sectors and how virtual services have been particularly valuable for specific populations, such as those receiving mental health services. Other Committee member points resonated, including that there are considerations that were brought to bear by the panelists such as the appreciation for the litany of potential barriers, startup costs, and the importance of interdisciplinary collaborations, training, and cooperative learning.

Summary: PTAC held its first theme-based discussion on telehealth on September 16, 2020. Given the health care crisis associated with COVID-19 and the massive increase in the use of telehealth technology to ensure continued health services, the Committee pursued a public dialogue on telehealth in relation to care delivery via APMs. Since evidence and information on this topic are still emerging, PTAC accessed subject matter experts in telehealth and health care delivery as well as the expertise of previous proposal submitters who had incorporated telehealth-related components into their proposals. Both panelists and public commenters imparted important knowledge for PTAC to take into consideration as they review future proposals. One of the key points relates to the importance of ensuring that virtual technology is a tool that enables, rather than worsens, access to services. Additional insights from the discussion suggest that payment policies related to APMs that incorporate virtual care should be flexible and not overly complicated, that there may be a place for telehealth in FFS payment models, and that some costs relating to virtual care extend beyond the provider-patient visit. Finally, it is likely that policies and outcome analyses will be necessary to ensure that telehealth aids in optimizing health care services and value-based transformation. In addition to informing PTAC's review of future proposals, input received from the public meeting may also serve PTAC in potential comments and recommendations to the Secretary on the use of telehealth in PFPMs.

Appendix A:

Panel Composition:

Previous PTAC Proposal Submitters' Panel:

- David Basel, MD, Avera Health (Intensive Care Management in Skilled Nursing Facility Alternative Payment Model (ICM SNF APM) proposal)
- Stetson Berg, MHA, University of New Mexico Health Sciences Center (ACCESS Telemedicine: An Alternative Healthcare Delivery Model for Rural Cerebral Emergencies proposal)
- Jeffrey Davis, MS, American College of Emergency Physicians (Acute Unscheduled Care Model (AUCM): Enhancing Appropriate Admissions proposal)
- Lawrence Kosinski, MD, MBA, SonarMD, Inc. (Project Sonar proposal)
- Barbara L. McAneny, MD, Innovative Oncology Business Solutions (Making Accountable Sustainable Oncology Networks (MASON) proposal)
- Heidi Robertson Cooper, MPA, American Academy of Family Physicians (Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care proposal)

Subject Matter Expert Panel & Perspectives:

- Sanjeev Arora, MD, MACP, FACG (Project ECHO): *Academic Research, Telehealth Innovation Perspectives*
- Chad Ellimoottil, MD, MS (University of Michigan): *Academic Research, Policy Perspectives*
- Lewis Levy, MD, FACP (Teladoc Health): *Telehealth/IT Perspective*
- Lee Schwamm, MD (Partners Healthcare): *Provider, Information Technology, Academic Research, Telehealth Innovation Perspectives*
- Sophia Tripoli, MPH (Families USA): *Patient Advocacy, Disability Perspectives*
- Anne Tumlinson (ATI Advisory): *Long-Term Care, Disability, Policy Perspective*
- Charles A. Zonfa, MD, MBA (SummaCare): *Payer Policymaker Perspective*

Appendix B:

Summary of Comments and Recommendations Made by Panelists and Public Commenters

1. Comments on General Topics Regarding the Use of Telehealth, Including Patient Access:

- Relaxed regulations enabled providers to scale-up telehealth quickly, in particular allowing providers to engage in services across licensure boundaries and expansion to advanced-care practitioners.
- To date, no abuses associated with telehealth have surfaced.
- Telehealth is part of a toolkit that also requires care integration and virtual services that provide support across the team to ensure coordinated care.
- There is value in telehealth as a frontline assessment tool.
- It was noted that there is data on improvements in the patient experience (e.g., wait times) and greater adherence to care plans under telehealth, and data showing no evidence of inappropriate increases in utilization.

- High-functioning health systems operating under a risk-based model were able to serve the aging (including long-term care) population using telehealth.
- Success in health care delivery including the use of telehealth requires the avoidance of siloed care delivery and team-based approaches to care including virtual-teleconference care support.
- Telehealth-enabled virtual health care delivery is an asset, an additional tool in the toolkit for care delivery, but shouldn't supplant in-person care services: Care should be given at the right time by the right provider in the right modality, which may include telehealth services.
- Audio-only services were key to ensuring on time, useable care delivery—in particular for patients who were not technologically savvy and also most vulnerable, such as those who are elderly.
- Models/waivers, etc. enabled emergency departments to use pre-triage services to avert unnecessary emergency services use.
- Telehealth services enable proactive engagement in health care services, which is particularly important for patients with chronic conditions.
- Expansion of telehealth has been particularly successful in addressing mental health and substance-use disorder issues. While telehealth in other specialties has fallen off from its peak to around 20 percent of total visits, demand has remained strong in behavioral health.
- Policy needs to focus on the impact of telehealth on disparities in access, costs and outcomes.
- **Caution:** Vulnerable populations with ongoing virtual care needs, such as the aging population, reside outside of nursing homes and without digital awareness nor social supports to assist them in using telehealth services, and are in essence on “islands.” To ensure adequate access to care via telehealth/virtual services, appropriate, strategic care planning is necessary to support their adaptation and enable this population to scale up.
- **Caution:** Disparities in services will arise for patients who cannot readily pivot to telehealth, and telehealth itself can worsen disparate care. Sources of worsening care can stem from the remarkable obstacles associated with broadband issues, the digital divide, individuals who lack support at home, and those with visual, hearing or other impairments.
- **Caution:** Protecting patient privacy is important. The challenge is balancing security with simplicity. Some patients do not want to download an application (“app”) with location tracking.

2. Comments on Financial and Other Mechanisms that Can Optimize the Use of Telehealth:

- Providers already engaged in APMs were fastest to adapt in their use of virtual technologies.
- General consensus was that the relaxed regulations that stemmed from the PHE spurred an almost immediate provider engagement in the use of virtual care. The relaxed regulations removed barriers and complexities to enable such engagement.
- Billing complexity is the biggest barrier to effective incorporation of telehealth into a system of patient care. Incorporating telehealth into an APM may remove this barrier.
- There need to be considerations related to payment parity between in-person and virtual care services
- Telehealth helps Accountable Care Organizations (ACOs) by preventing hospitalizations (and savings pay for telehealth).
- There is importance in focusing on APMs that include prospective, risk-adjusted payments that allow for care that is “direct to consumer” and not fragmented.

- There needs to be flexibility in place for payment, and there is a place for FFS in the scheme of payment approaches, e.g. specialty care services that may not be a part of an ACO or bundled or other payment schema.
- Solutions for the future should be flexible, allowing the provider to determine the right time, right place and right forum in which care should be provided—enabling the provider to decide between patient-centered virtual care and in-person care.
- Payment should be equitable and enable the costs associated with delivery of care in a virtual framework (which can become more complex than in-person care).
- Extensive cost analyses are necessary to determine and inform appropriate reimbursements.
- Bureaucratic complexities with practicing across state lines can be a barrier to telehealth expansion, but those are also safeguards against bad actors prescribing opioids across state lines to patients they've never seen, without at least speaking to those patients' physicians.

3. Comments Related to Meaningfully Expanding Telehealth through Delivery System Reform:

- Value-based purchasing and APMs helped providers stay open during the PHE and preserve patient access, although barriers in access surfaced, leading to concerns that virtual health care delivery could further disparate care.
- We cannot create a new silo, this time with telehealth. Virtual care must be designed with payment structures that enable and ensure coordinated care across lines of service.
- Telehealth is a tool, but should not be considered the only modality to providing care.
- Telehealth is natural in APMs, but we should not forget that it continues to have a role in FFS care (though making FFS less appealing could help drive providers to value-based payment and promote telehealth).
- Long-term guarantee of reimbursements (such as a five-year roadmap) is key to encouraging health systems to make large investments in telehealth infrastructure, instead of 1-2 year demonstration projects. Stable financing mechanisms and incentives will help providers invest and lower costs, increase value, such as using virtual care to aid in averting preventable emergency services visits, hospitalizations and ensuring appropriate follow-up and continued care coordination.
- Policymakers need to be courageous in offering flexibility. Simplicity is also key, rather than many models.
- Interoperability and reliable data information exchange is crucial to appropriate use of telehealth.
- Telehealth policy should include an emphasis on interprofessional, multidisciplinary collaboration (such as nurses).
- There needs to be a new model for collaborative learning built into value-based care that builds the knowledge and confidence of primary care providers. Knowledge is expanding so rapidly that a mechanism to pay for its diffusion is needed so that providers keep up with advances.