

Physician-Focused Payment Model Technical Advisory Committee

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June 4, 2021

Xavier Becerra, Secretary

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Becerra:

On behalf of the Physician-Focused Payment Model Technical Advisory Committee (PTAC), I am pleased to submit PTAC's report on the role of telehealth in optimizing health care delivery and value-based transformation in the context of Alternative Payment Models (APMs) and physician-focused payment models (PFPMs). Section 1868(c) of the Social Security Act directs PTAC to: 1) review PFPMs submitted to PTAC by individuals and stakeholder entities; 2) prepare comments and recommendations regarding whether such models meet criteria established by the Secretary of Health and Human Services (HHS); and 3) submit these comments and recommendations to the Secretary. Within this context, from time to time, it may be beneficial for PTAC to reflect on proposed PFPMs that have been submitted to the Committee to provide further advisement on pertinent issues regarding effective payment model innovation in APMs and PFPMs. In some cases, the importance of an emerging topic may lead PTAC to consider how proposals the Committee has reviewed in the past may inform that emerging topic. For example, PTAC may wish to assess information in previously submitted proposals and other sources that could serve to further inform the Secretary, as well as PTAC itself on these topics. This is the case regarding the topic of telehealth.

Between December 2016 and March 2020, PTAC received 18 PFPM proposals that included telehealth as a component. Given the unprecedented expansion of telehealth in response to the COVID-19 public health emergency (PHE), and the fact that a large number of the proposed PFPMs that were submitted to PTAC included telehealth as part of the care delivery model, PTAC saw value in assessing these proposals, along with current information on telehealth and value-based care transformation. To ensure that the Committee was fully informed, PTAC's September 2020 and December 2020 public meetings included theme-based discussions on telehealth in the context of APMs and PFPMs. PTAC also requested input from the public during the public meetings and through a Request for Input (RFI).

The September theme-based discussion included panel discussions with previous submitters and other subject matter experts on telehealth. The previous submitters and experts noted various observations related to their experience with telehealth, including:

- Exponential increases that occurred in telehealth use during the PHE, especially for primary care, when regulatory requirements were relaxed (including positive impacts associated with the easing of geographical restrictions);
- The ability of providers engaged in APMs to adapt quickly to the increased use of virtual health care delivery during the PHE to ensure continuity of care; and
- The promise of virtual health care's ability to improve access to care, and the role of telehealth as a tool in conjunction with in-person care to optimize care across systems of care.

Experts also raised several important topics for further consideration, such as:

- The need to ensure that virtual health care does not exacerbate disparities in care among vulnerable populations, including those needing long-term support services residing either at home or in long-term care facilities;
- The impact of costs associated with the use of virtual technology on patients' ability to access appropriate telehealth services, and the relevance of audio-only visits within this context;
- The development of standards to achieve balance between optimal use of virtual and in-person services;
- The importance of enabling data sharing and integrating the use of telehealth modalities with usual sources of "person-centered" care so that telehealth does not become another health care "silo"; and
- The opportunity to employ APMs to facilitate a cultural shift away from using telehealth as an isolated event to using telehealth as a component of routine, team-based care for patients.

This report provides PTAC's findings, comments, and research questions regarding the role of telehealth in optimizing health care delivery and value-based care transformation within APMs and PFPs. Key highlights include:

- Telehealth can be an effective and efficient tool for improving and optimizing health care delivery, both by augmenting traditional services, as well as enabling additional aspects of care such as patient monitoring.
- Understanding the efficacy of telehealth and the extent to which telehealth services substitute for, or complement, existing services is very important, especially in the context of different services (e.g., primary versus specialty care), providers (e.g., from physicians to

community health workers), settings (e.g., home, office, or inpatient) and other issues (e.g., safety).

- Value-based payment models and APMs may be the best approach for advancing optimal use of telehealth within the health care system. Depending on their design, APMs could support a cultural shift from using telehealth in a discrete encounter to viewing health holistically as part of an interdisciplinary team-based care model.
- Building telehealth into APMs and PFPs may help to ensure that telehealth services are used appropriately and do not inappropriately increase Medicare spending. APMs may also be an efficient way to incorporate important payment components such as risk adjustment, risk sharing, service payment differentials based on location, and multi-payer alignment; and to test the efficacy of various telehealth interventions.
- APMs that incorporate prospective, population-based payments could provide predictable financing for investments in adoption and integration of telehealth.
- It will be important to consider the balance between flexibility of providing certain services versus administrative tracking and complexity -- including issues related to documentation (especially within electronic health records), privacy, cybersecurity, regulation, and care coordination/integration.
- Program integrity is an important concern, because rapid growth of a service like telehealth has substantial potential for overuse, misuse, and fraud. Monitoring of outcomes will be important.
- Some stakeholders discussed the importance of ensuring that the financial benefits from using telehealth outweigh the cost of implementing it, whether in a FFS environment or in an APM.
- Avoiding the exacerbation of disparities is important, as issues such as language, access to and ease of use of technology, and type of technology could adversely affect the potential benefits of telehealth for vulnerable populations.
- It is also important to understand the cost associated with services such as providing real-time language translation as part of telehealth.
- APMs may be able to use telehealth to increase access to services in areas with limited coverage.
- It will be important to determine when audio-only access is appropriate because telephone-only modalities may be necessary to ensure access for populations where infrastructure is more limited, and there is variation in beneficiaries' ability to access and use technology required for telehealth.

This report summarizes information that PTAC has gleaned from a review of previous PFPM proposals and other literature that addressed this important topic, and input received from the

panel discussions and public comments, which will help to inform PTAC in its review of future proposals. This material has informed the Committee's comments, which are summarized in the following broad topic areas in this report:

- Category 1: Addressing Telehealth Infrastructure: Provider and Beneficiary Needs;
- Category 2: Addressing Telehealth Barriers and Enablers: Policies Related to Access and Optimization; and
- Category 3: Addressing Payment Issues: Paying for Telehealth under PFPs or APMs.

The members of PTAC appreciate your support of our shared goal of improving the Medicare program for both beneficiaries and the physicians who care for them. PTAC members would be happy to discuss any of these observations with you. However, the Committee appreciates that there is no statutory requirement for the Secretary to respond to these comments.

Sincerely,

//Jeffrey Bailet//

Jeffrey Bailet, MD

Chair

Attachment

REPORT TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

*The Role of Telehealth in Optimizing Health Care Delivery and
Value-Based Transformation within Alternative Payment Models and
Physician-Focused Payment Models*

June 4, 2021

About This Report

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) was established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to: 1) review physician-focused payment models (PFPMs) submitted by individuals and stakeholder entities; 2) prepare comments and recommendations regarding whether such models meet criteria established by the Secretary of Health and Human Services (HHS); and 3) submit these comments and recommendations to the Secretary. PTAC reviews submitted proposals using criteria established by the Secretary in regulations at 42 CFR §414.1465.

Within this context, from time to time, it may be beneficial for PTAC to reflect on proposed PFPMs that have been submitted to the Committee to provide further advisement on pertinent issues regarding effective payment model innovation in APMs and PFPMs. Given the unprecedented expansion of telehealth in response to the COVID-19 public health emergency, and the fact that a large number of the proposed PFPMs that have been submitted to PTAC included telehealth as part of the care delivery model, PTAC saw value in assessing these proposals, along with current information on telehealth and value-based care transformation. To ensure that the Committee was fully informed, PTAC's September 2020 and December 2020 public meetings included theme-based discussions on telehealth in the context of APMs and PFPMs.

This report summarizes PTAC's comments and research questions regarding the role of telehealth in optimizing health care delivery and value-based transformation within APMs and PFPMs. This report also includes: 1) a summary of PTAC's comments; 2) a summary of the characteristics of proposals that have previously been submitted to PTAC which included a telehealth component; 3) an overview of key issues relating to telehealth and value-based care transformation; and 4) a list of additional resources related to this theme-based discussion that are available on the Assistant Secretary for Planning and Evaluation (ASPE) PTAC website.

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SUMMARY STATEMENT

Between December 2016 and March 2020, PTAC received 18 physician-focused payment model (PFPM) proposals that included telehealth as a component. Given the unprecedented expansion of telehealth in response to the COVID-19 public health emergency (PHE),ⁱ and the fact that a large number of the proposed PFPMs that were submitted to PTAC included telehealth as part of the care delivery model, PTAC saw value in assessing these proposals, along with current information on telehealth and value-based care transformation.

To ensure that the Committee was fully informed, PTAC's September 2020 and December 2020 public meetings included theme-based discussions on telehealth in the context of Alternative Payment Models (APMs). PTAC also requested input from the public during the public meetings and through a Request for Input (RFI). The September theme-based discussion included panel discussions with previous submitters and other subject matter experts on telehealth. The previous submitters and experts noted various observations related to their experience with telehealth, including:

- Exponential increases that occurred in telehealth use during the (PHE, especially for primary care, when regulatory requirements were relaxed (including positive impacts associated with the easing of geographical restrictions);
- The ability of providers engaged in APMs to adapt quickly to the increased use of virtual health care delivery during the PHE to ensure continuity of care; and
- The promise of virtual health care's ability to improve access to care, and the role of telehealth as a tool in conjunction with in-person care to optimize care across systems of care.

Experts also raised several important topics for further consideration, such as:

- The need to ensure that virtual health care does not exacerbate disparities in care among vulnerable populations, including those needing long-term support services residing either at home or in long-term care facilities;
- The impact of costs associated with the use of virtual technology on patients' ability to access appropriate telehealth services, and the relevance of audio-only visits within this context;
- The development of standards to achieve balance between optimal use of virtual and in-person services;
- The importance of enabling data sharing and integrating the use of telehealth modalities with usual sources of "person-centered" care so that telehealth does not become another health care "silo"; and

- The opportunity to employ APMs to facilitate a cultural shift away from using telehealth as an isolated event to using telehealth as a component of routine, team-based care for patients.

This report provides PTAC’s findings, comments, and research questions regarding the role of telehealth in optimizing health care delivery and value-based care transformation within APMs and PFPMs. Key highlights include:

- Telehealth can be an effective and efficient tool for improving and optimizing health care delivery, both by augmenting traditional services, as well as enabling additional aspects of care such as patient monitoring.
- Understanding the efficacy of telehealth and the extent to which telehealth services substitute for, or complement existing services is very important, especially in the context of different services (e.g., primary versus specialty care), providers (e.g., from physicians to community health workers), settings (e.g., home, office, or inpatient) and other issues (e.g., safety).
- Value-based payment models and APMs may be the best approach for advancing optimal use of telehealth within the health care system. Depending on their design, APMs could support a cultural shift from using telehealth in a discrete encounter to viewing health holistically as part of an interdisciplinary team-based care model.
- Building telehealth into APMs and PFPMs may help to ensure that telehealth services are used appropriately and do not inappropriately increase Medicare spending. APMs may also be an efficient way to incorporate important payment components such as risk adjustment, risk sharing, service payment differentials based on location, and multi-payer alignment; and to test the efficacy of various telehealth interventions.
- APMs that incorporate prospective, population-based payments could provide predictable financing for investments in adoption and integration of telehealth.
- It will be important to consider the balance between flexibility of providing certain services versus administrative tracking and complexity—including issues related to documentation (especially within electronic health records), privacy, cybersecurity, regulation, and care coordination/integration.
- Program integrity is an important concern, because rapid growth of a service like telehealth has substantial potential for overuse, misuse, and fraud. Monitoring of outcomes will be important.
- Some stakeholders discussed the importance of ensuring that the financial benefits from using telehealth outweigh the cost of implementing it, whether in a FFS environment or in an APM.

- Avoiding the exacerbation of disparities is important, as issues such as language, access to and ease of use of technology, and type of technology could adversely affect the potential benefits of telehealth for vulnerable populations.
- It is also important to understand the cost associated with services such as providing real-time language translation as part of telehealth.
- APMs may be able to use telehealth to increase access to services in areas with limited coverage.
- It will be important to determine when audio-only access is appropriate because telephone-only modalities may be necessary to ensure access for populations where infrastructure is more limited, and there is variation in beneficiaries' ability to access and use technology required for telehealth.

This report summarizes information that PTAC has gleaned from a review of previous PFPM proposals and other literature that addressed this important topic, and input received from the panel discussions and public comments, which will help to inform PTAC in its review of future proposals. This material has informed the Committee's comments, which are summarized in the following broad topic areas in this report:

- Category 1: Addressing Telehealth Infrastructure: Provider and Beneficiary Needs;
- Category 2: Addressing Telehealth Barriers and Enablers: Policies Related to Access and Optimization; and
- Category 3: Addressing Payment Issues: Paying for Telehealth under PFPMs or APMs.

I. PTAC REVIEW OF TELEHEALTH IN THE CONTEXT OF APMS AND PFPMs

Between December 2016 and March 2020, PTAC completed reviews of 18 PFPM stakeholder-submitted proposals that included telehealth as a component. This volume of proposals suggests considerable stakeholder interest in using telehealth as a component of APMs and PFPMs. Given the unprecedented expansion of telehealth in response to the PHE, and the fact that a large number of the proposed PFPMs that were submitted to PTAC included telehealth as part of the care delivery design, PTAC saw value in assessing these proposals, along with current information on telehealth and value-based care transformation.

To ensure that the Committee was fully informed, an environmental scan was developed to provide background information on telehealth, the role of telehealth in APMs and PFPMs, and issues and opportunities associated with optimizing telehealth in an APM. PTAC collected additional information during a theme-based discussion on telehealth in the context of APMs and PFPMs that was held on September 16, 2020, which included: 1) panel discussions with six stakeholders who had previously submitted PFPM proposals with a telehealth component to

PTAC; 2) perspectives from a diverse group of subject matter experts; and 3) public comments from stakeholders.

PTAC also requested additional input from the public through a Request for Input (RFI) which was posted on September 18, 2020. PTAC received nine public comments in response to the RFI. Additionally, a supplement to the environmental scan was developed to provide additional context based on recently published research. Subsequent to the September public meeting, PTAC formed a Preliminary Comments Development Team (PCDT) consisting of three PTAC members (Jay S. Feldstein, DO; Luran Hardin, MSN, FAAN; and Carrie H. Colla, PhD). The PCDT used the information that had been gathered to develop a set of suggested comments, which were deliberated on during a follow-up theme-based discussion on this topic that was held during the Committee's December 8, 2020 Public Meeting.

The remaining sections of this report provide a summary of PTAC's findings and comments (including related research questions); a summary of the characteristics of proposals that have previously been submitted to PTAC which included a telehealth component; an overview of key issues relating to telehealth and value-based care transformation; and a list of additional resources related to PTAC's telehealth theme-based discussions that are available on the Assistant Secretary for Planning and Evaluation (ASPE) PTAC website.

II. DEFINITION OF TELEHEALTH

The Health Resources & Services Administration's (HRSA) Office for the Advancement of Telehealth (OAT) defines telehealth as "the use of electronic information and telecommunication technologies to support long-distance clinical health care; patient and professional health-related education; public health; and health administration."ⁱⁱ This definition emphasizes that telehealth is more than one kind of service. Instead, it covers multiple services and intervention types, which may be referred to by more specific subcategory terminology. Stakeholders may use various terms, including telemedicine, often interchangeably to refer to forms of electronic communication regarding health.

The HRSA OAT definition also encompasses different technical platforms and provider workflows. Information may be transmitted using the telephone, the Internet (e.g., voice-over-IP and streaming video), or wireless communication infrastructure and mobile devices (mHealth).ⁱⁱⁱ This definition encompasses services provided under Medicare section 1834(m), and recent statutory and regulatory expansions.

Telehealth services, including those authorized through Medicare as telehealth or telecommunications, may use "live" or synchronous exchange of information; use a store-and-forward or asynchronous approach; or use a continuous data feed for ongoing analysis.^{iv}

III. CHARACTERISTICS OF TELEHEALTH-RELATED PTAC PROPOSALS

Between December 2016 and March 2020, PTAC received 35 proposed PFPs submitted by stakeholders, including 18 proposals that included telehealth as a component. Among these proposals: five included telehealth as a central feature of the proposed model; nine proposals included telehealth as an aspect of the proposed care delivery and/or payment model; and four proposals included telehealth as an optional component with the potential for adoption under the proposed model (see Appendix 2 for a list of these proposals).

The PTAC proposals reflect the submitters' proposed use of telehealth services and their anticipated role in their proposed models prior to the PHE. The proposals included different telehealth modalities and different approaches to using telehealth, and many of the proposals incorporated more than one approach to using telehealth. Of the 18 proposals that included telehealth components and were reviewed by PTAC by March 2020:

- **Sixteen incorporated telephonic and/or live-videoconferencing synchronous services.** These services included: videoconferences or telephone calls with providers to provide consultations, evaluations, or monitoring; nurse triage lines; electronic communication between primary care providers and specialists; training of providers; and follow-up care.
- **Seven included remote patient monitoring via telehealth.** Monitoring services included general monitoring through videoconferencing or phone, monitoring via Bluetooth-enabled biometric devices to trigger early interventions, monitoring of quality measures, and supporting data collection.
- **Seven included distinct mobile health (mHealth) services.** Services proposed were generally smart phone applications or secure messaging systems to complement patient monitoring or synchronous services.
- **Two incorporated asynchronous services** that could support access to patients' health records.

As with all PTAC proposal submissions, the 18 proposals that included a telehealth component also varied by populations served and provider settings. Additionally, the telehealth-related PTAC proposals proposed a variety of proposed payment models, including specific reimbursements for telehealth services with add-on or capitated per beneficiary per month (PBPM) payments with shared risk; continued fee-for-service (FFS) during an episode or fixed episode payments with shared risk and prospective or retrospective reconciliation; and additional payments to the Medicare Physician Fee Schedule (MPFS) with either no downside risk or shared risk. Exhibit 1 includes examples of how telehealth would be incorporated into the proposed care delivery and/or payment models of several of the PTAC proposals and the overall objectives of these proposed models.

Exhibit 1: Summary of the Features of Selected PTAC Telehealth-Related Proposals*

Submitter and Proposal	Telehealth Modality	Clinical Focus, Provider Type, and Place of Service	Care Delivery and Payment Model Objectives
<ul style="list-style-type: none"> Avera Health Intensive Care Management in Skilled Nursing Facility Alternative Payment Model (ICM SNF APM) 	<ul style="list-style-type: none"> Synchronous (live-video, telephone); Asynchronous 	<ul style="list-style-type: none"> Clinical Focus: SNFs and NFs Provider: Geriatrician Care Teams for SNFs and NFs Place of Service: SNFs and NFs 	<ul style="list-style-type: none"> Improve access to care; provide enhanced and/or 24/7 access to care; improve quality of care and associated health outcomes; reduce avoidable and costly emergency department (ED) visits and hospitalizations
<ul style="list-style-type: none"> University of New Mexico Health Sciences Center ACCESS Telemedicine: An Alternative Healthcare Delivery Model for Rural Cerebral Emergencies 	<ul style="list-style-type: none"> Synchronous (live-video) 	<ul style="list-style-type: none"> Clinical Focus: Cerebral emergencies Provider: Neurologists and neurosurgeons; providers in rural and community hospitals Place of Service: Inpatient; outpatient; or emergency department in rural/ community hospital 	<ul style="list-style-type: none"> Improve access to care/quality of specialist care in rural/remote areas; provide enhanced and/or 24/7 access to care; improve quality of care and associated health outcomes; reduce avoidable and costly transfers and patient travel; improve financial viability of rural and community hospitals
<ul style="list-style-type: none"> American College of Emergency Physicians Acute Unscheduled Care Model (AUCM): Enhancing Appropriate Admissions 	<ul style="list-style-type: none"> Synchronous (telephone); Modality not Specified 	<ul style="list-style-type: none"> Clinical Focus: Patients discharged home from ED and in a care transition Provider: ED physician; Part B provider Place of Service: Patient home 	<ul style="list-style-type: none"> Improve quality of care and associated health outcomes; improve care coordination and delivery, and patient choice; reduce avoidable and costly ED visits
<ul style="list-style-type: none"> Illinois Gastroenterology Group and SonarMD Project Sonar 	<ul style="list-style-type: none"> Synchronous (telephone); mHealth; Remote Patient Monitoring 	<ul style="list-style-type: none"> Clinical Focus: Crohn's disease Provider: Gastroenterology practices Place of Service: Patient home 	<ul style="list-style-type: none"> Improve access to care; improve patient engagement; reduce avoidable and costly ED visits and inpatient utilization
<ul style="list-style-type: none"> Innovative Oncology Business Solutions Making Accountable Sustainable Oncology Networks (MASON) 	<ul style="list-style-type: none"> Synchronous (telephone); mHealth; Modality not Specified 	<ul style="list-style-type: none"> Clinical Focus: Cancer Provider: National Cancer Care Alliance (NCCA) oncology physicians Place of Service: Patient home 	<ul style="list-style-type: none"> Improve access to care; provide enhanced and/or 24/7 access to care; improve quality of care and associated health outcomes

* Information on the other PTAC proposals that included a telehealth component can be found in Appendix 2.

IV. KEY ISSUES RELATING TO OPTIMIZING TELEHEALTH FOR VALUE-BASED CARE TRANSFORMATION IN THE CONTEXT OF APMS AND PFPMS

This section describes key issues related to optimizing telehealth for value-based care transformation in the context of APMS and PFPMS that were identified during PTAC's telehealth theme-based discussions in September 2020 and December 2020. These key themes are drawn from the publicly available materials that are highlighted in Appendix 3.

IV.A. General Observations About the Use of Telehealth During the Public Health Emergency

Telehealth utilization increased markedly after the beginning of the PHE.^v Drawing from their own experiences, stakeholders identified a number of important benefits from having increased access to the option of providing virtual care during this period of time, including the ability to:

- Maintain patients' access to essential services while generating some revenue (particularly for providers who relied on FFS reimbursement);
- Assess which patients needed to come in for a physical, in-person visit – thereby reducing potential exposure to COVID-19 for patients and providers, and decreasing the number of no-shows for in-person visits due to concerns about exposure;
- Use telehealth for patients in their homes, particularly by means of telephone in rural and tribal areas that lack broadband for using visual telehealth;
- Create backup plans to allow for shifting to audio-only services as needed in the event of technical difficulties;
- Reduce emergency department (ED) utilization through triage by a provider, providing access to a multidisciplinary team of providers for nursing home patients, and facilitating follow-up after ED discharge;
- Reduce cross-facility transfers via telehealth consultations for subspecialty care;
- Increase the use of transitional care;
- Facilitate effective and efficient communication among providers in the care team; and
- Improve beneficiaries' access to care and compliance with prescribed therapies – including the use of remote monitoring to proactively manage patients' care.

IV.B. Opportunities to Improve Health Care Through Telehealth

The stakeholders who participated in the panel discussions noted that increased telehealth utilization during the PHE revealed that telehealth can be an effective and efficient mechanism for improving care delivery. Based on this experience, these stakeholders generally agreed that, even after the PHE, use of telehealth will likely remain higher than pre-PHE levels. This is particularly true for behavioral health care; stakeholders indicated that virtual health care delivery has been especially important for individuals receiving behavioral health services.

Stakeholders emphasized that telehealth is a tool that can assist in providing value-based care. They discussed the importance of having coordination between telehealth and in-person interventions in order to achieve the desired outcomes – including ensuring that other providers in the care delivery network are aware of what happens during a telehealth visit.

Some stakeholders noted that telehealth can facilitate the transition to team-based and patient-centered care delivery approaches. Stakeholders emphasized the importance of ensuring care continuity and using virtual care to complement and extend the benefit from the important “hands-on” attention that comes from in-person care. They stated that integrating telehealth with interoperable electronic health record (EHR) systems would facilitate data sharing with a beneficiary’s usual source of care when different providers are involved.

Some stakeholders emphasized the importance of payer, provider, and technology partnerships to develop best practices for telehealth adoption and use. They recognized that these partnerships would require collaboration across professions, disciplines, and organizations. Some also noted the importance of developing best practices that balance the potentially competing attributes of simplicity and flexibility.

IV.C. Important Barriers to Effective Adoption and Use of Telehealth

Stakeholders indicated that regulatory, technological, and operational barriers can affect the implementation and use of telehealth. For example, they noted that prior to the PHE, coverage restrictions related to payment policy, type of service, site of care, and licensure requirements had inhibited the use of telehealth. Conversely, stakeholders indicated that when these restrictions were relaxed following the start of the PHE, the use of telehealth markedly increased.^{vi,vii,viii} Stakeholders agreed that many of the waivers that were included in the Coronavirus Preparedness and Response Supplemental Appropriations Act helped to alleviate some coverage-related barriers. However, they noted that these waivers are not guaranteed to continue post-PHE.

Beyond coverage-related issues, stakeholders indicated that certain aspects of payment policy – such as complex billing rules and cost-sharing requirements – can pose a barrier to telehealth adoption and use. Stakeholders also indicated that substantial infrastructure and start-up costs can also affect the adoption and use of telehealth, as can the challenge of integrating telehealth into workflows associated with usual care. Additionally, stakeholders noted that many telehealth applications lack integration with EHRs, creating a risk for telehealth to become another data “silo.”

Stakeholders also discussed some patient-related barriers to increased use of telehealth. For example, they indicated that some patients may have concerns about privacy that may make them resistant to the idea of downloading specialized applications to facilitate video telehealth

visits. Stakeholders also noted that there is a perception among some patients that the quality of care through telehealth may not be equivalent to in-person care.

Importantly, stakeholders also emphasized that individuals lacking access to broadband connectivity, hardware, software, or other resources are not likely to benefit from increased access to telehealth as much as others. Because of this disparity, some stakeholders warned that increased reliance on telehealth may exacerbate disparities in care among vulnerable populations, as beneficiaries who lack familiarity or comfort with necessary technologies, or who require long-term support or assistance, also face barriers in benefiting from telehealth. Stakeholders indicated that these groups may include those with physical or intellectual impairments that may make it difficult for them to join a visual call alone, those requiring language translation, and those requiring culturally-appropriate educational resources. Stakeholders also discussed the importance of effectively serving older adults who live in the community, not in nursing homes or assisted living, in order to reduce hospital utilization.

IV.D. Opportunities to Address Barriers

Stakeholders identified a number of potential approaches for addressing the barriers that have been described above. For example, stakeholders discussed the need for additional research to understand appropriate uses of telehealth. Stakeholders also suggested finding mechanisms to provide sufficient training and funding necessary to adopt telehealth (including funding for infrastructure). Additionally, most of the stakeholders discussed the importance of having protections in place to help secure patients' privacy through maintaining Health Insurance Portability and Accountability Act (HIPAA) compliance and implementing patient education.

To reduce fragmentation and support interoperability, stakeholders discussed the need for improved data sharing and suggested encouraging integration between telehealth systems and EHRs. Some stakeholders discussed the importance of maximizing flexibility for providers to deliver care in ways that make the most sense for their patients, using telehealth along with other modalities. Several stakeholders suggested treating virtual care services similarly to inpatient care, and suggested that many services falling under telehealth (e.g., virtual office visits) should be viewed as a separate setting or modality for existing services, rather than as a new service.

To address issues related to equity, stakeholders noted the importance of ensuring broadband access, patient education, and translation services. Stakeholders also discussed the importance of accurately collecting data on race, ethnicity, and primary language in order to consider the impact of telehealth on disparities; and addressing issues related to social determinants of health. Finally, they noted the importance of considering how to cover telehealth services that are delivered via telephone, in order to allow access to virtual care for those who are unable to effectively use audio-visual technologies.

Finally, several stakeholders discussed the need for secure, predictable financing in order for health systems to be able to make the necessary investment for expanding the use of telehealth. Stakeholders also discussed the importance of considering the impact of telehealth on cost and clinical outcomes. For example, some stakeholders emphasized the importance of adapting current quality measures to track comparability between care that is delivered virtually and in-person. Additionally, some stakeholders discussed the importance of ensuring that the financial benefits from using telehealth outweigh the cost of implementing it, whether in a FFS environment or in an APM.

IV.E. Importance of APM or PFPM Frameworks

Some stakeholders noted that value-based payment models and APMs may be the best approach for advancing optimal use of telehealth within the health care system. Stakeholders indicated that depending on their design, APMs could support a cultural shift from using telehealth in a discrete encounter to viewing telehealth holistically as part of an interdisciplinary team-based care model. They also indicated that APMs that incorporate prospective, population-based payments could provide predictable financing for investments in adoption and integration of telehealth.

Additionally, stakeholders noted that APMs with value-based incentives could help to mitigate potential concerns relating to program integrity or over-utilization in the context of telehealth. Within this context, the system would be responsible for the entire care of the patient, which would provide incentives for appropriate utilization of telehealth, consistent with patient needs. Stakeholders indicated that APMs can also help to support innovative approaches, such as care delivery models that use telehealth to provide access to multidisciplinary teams of providers for beneficiaries.

Stakeholders also indicated that some APMs may be able to use telehealth to increase access to services in areas with limited provider coverage. However, while stakeholders generally viewed value-based care as being a natural home for telehealth, one stakeholder indicated that telehealth also has a role in FFS related to ensuring access to subspecialists who practice in academic medical centers.

V. COMMENTS AND RESEARCH QUESTIONS FOR CONSIDERATION BY THE SECRETARY

Prior sections described findings from PTAC telehealth-related proposals and input from stakeholders. Based on this information, this section summarizes PTAC's comments and research questions regarding the role of telehealth in optimizing health care delivery and value-based transformation in the context of APMs and PFPMs, along with related research questions. These comments and research questions are organized in three categories of priority areas:

- Category 1: Addressing Telehealth Infrastructure: Provider and Beneficiary Needs
- Category 2: Addressing Telehealth Barriers and Enablers: Policies Related to Access and Optimization
- Category 3: Addressing Payment Issues: Paying for Telehealth under PFPs or APMs

PTAC’s comments and research questions are included after a discussion of relevant issues related to each of these topics. Additionally, Appendix 4 includes a complete list of the Committee’s comments.

V.A. Category 1: Addressing Telehealth Infrastructure: Provider and Beneficiary Needs

Stakeholders identified the need for infrastructure that addresses provider and beneficiary needs as a necessary prerequisite for optimizing the use of telehealth. In developing comments and research questions, the Committee identified several categories of infrastructure needs that warrant attention, including those that are:

- Important for vulnerable populations;
- Related to standards for telehealth adoption and use;
- Related to benchmarks and standards that vary by setting; and
- Related to understanding the cost of adoption for beneficiaries and providers.

Addressing disparities and focusing on the needs of vulnerable populations. When developing an approach for implementing telehealth, equity is an important consideration. Expanded use of virtual health care may exacerbate disparities in care among vulnerable populations who may not have access to or skills with the needed technologies. Subject matter experts emphasized the importance of developing methods to address the “digital divide,” including divides related to variation in beneficiaries’ adeptness with using technology, access to devices, access to broadband connectivity, and the ability or inability to use the required technology due to physical or cognitive impairments or a lack of caregiver support.

For example, one stakeholder discussed the needs of the aging population such as those with long-term support needs residing at home in the community, including those residing alone and with limited supports. Individuals in this situation may be isolated, especially if they have limited digital literacy or suffer from an impairment and do not live with a caregiver. Ensuring adequate access to care using telehealth for individuals in this circumstance requires appropriate strategic care planning – which can include patient education and conducting pre-telehealth visit testing.

There are also opportunities to address the social needs of vulnerable populations virtually by offering access to community health workers to supplement clinician-led services. Offering virtual access across clinical and social services is especially important for addressing the needs

of vulnerable populations requiring long-term support who increasingly remain at home. Additionally, telehealth can provide access to multidisciplinary teams of providers for beneficiaries in long-term care settings.

There is also a need for additional research on the best approaches for serving vulnerable populations through telehealth – such as the provision of real-time translation services for telehealth services for non-English speakers – as well as the related costs. Specifically, research is needed on how to improve access for these populations to telehealth and their capacity to use telehealth technology. Furthermore, research is needed on the design of APMs that can meet the needs of these individuals. Comments and research questions related to addressing disparities and focusing on vulnerable populations are listed in Exhibit 2.

Exhibit 2: PTAC Comments and Research Questions

Category 1: Beneficiary Needs: Addressing Disparities and Focusing on the Needs of Vulnerable Populations

Comment 1A. *Consider sponsoring a report on unintended consequences associated with widespread adoption and use of telehealth that addresses the exacerbation of disparities in care for specific populations due to the digital divide, language/communications needs, cognitive and physical impairments, and long-term services and supports (LTSS) needs; and for those living in the community with limited caregiver support.*

Comment 1B. *Consider partnering with a diverse array of stakeholders (including providers and those representing beneficiary voices) on development of standards for adoption of telehealth to address LTSS needs of community-dwelling populations and to address the impact of social isolation.*

Comment 1C. *Consider further research on unintended consequences of widespread use of telehealth: address disparities in care for specific populations, including those with impairments or those who require language translation and culturally competent education.*

Research Questions

- *How can the needs of these populations be addressed in the context of telehealth APMs?*
- *What features of an APM will or will not facilitate helping these populations benefit from access to telehealth?*

Addressing standards for adoption and use. Additional information is needed on appropriate standards for the adoption and use of telehealth. Key research questions relate to which workflows best accommodate the simultaneous use of telehealth care and in-person care in one system; which models best serve individuals with disabilities or without in-home support for telehealth; and which APM payment designs foster telehealth implementation and integrity of payment.

Implementation of various telehealth models may be most efficient within an APM or PFFM framework. A lack of coordination across payers and limited financial support for telehealth modalities have been barriers to widespread implementation of this service in APMs. Consistency across payers and payment policies implemented in an APM or PFFM framework could support the development of standards for telehealth adoption and harmonization of rules regarding coverage and payment for care delivered through a telehealth modality. Improved standardization could help to streamline implementation and facilitate providers' ability to implement and use telehealth.

Incentives established under APMs may offer an opportunity to shift from a culture of treating services delivered through telehealth as discrete events (e.g., a single medical visit) to viewing telehealth as a tool that is routinely used as part of an interdisciplinary team-based care model. For example, some stakeholders discussed the benefits of skilled nursing facility (SNF) care models that offer residents immediate, as-needed access to a multidisciplinary team of providers such as geriatricians and social workers using virtual care; and the difficulty of paying for this type of model without an APM. Stakeholders also viewed APMs as potentially providing greater financial stability to support investments in telehealth, and expressed concerns about uncertainty related to future payment policy for telehealth beyond the temporary changes that were made to modify or waive certain Medicare payment requirements using section 1135 of the Social Security Act (1135 waivers)^{ix} due to the PHE.

Both primary and specialty providers faced workflow challenges in undergoing a rapid switch to telehealth during the early months of the PHE. Examples included revising schedules to be appropriate for virtual care, educating patients, conducting a "pre-visit" to test technology, and building in the ability to shift from computer (audiovisual) to telephone (audio-only) if needed. It was also necessary for providers to develop an approach for determining when clinical conditions required an in-person visit to receive appropriate treatment.

For these reasons, additional research is needed on the means for expanding support to providers related to telehealth implementation; providing telehealth training to providers and patients; and conducting care coordination using telehealth. It is important to emphasize the value of research for developing care delivery standards that effectively employ telehealth in the context of routine, team-based care. Relevant topics include clinical decision standards that can help to identify when virtual care is appropriate, and approaches to workflow that recognize the need for a backup plan to provide access in the event of unexpected connectivity problems during a telehealth visit. Additionally, increasing reliance on telehealth could lead to data silos and exacerbate problems associated with fragmented care if information that is used and captured in a telehealth visit is not integrated into an interoperable EHR.

It will also be important to highlight questions regarding data security. Data storage needs for remote patient monitoring may be very robust, which may have implications for how to secure

the data. Similar to EHRs and other patient record systems, it will be necessary for telehealth platforms to have audit capacities that help to protect personal health data. Exhibit 3 lists PTAC's comment and research questions regarding addressing standards for telehealth adoption and use.

Exhibit 3: PTAC Comment and Research Questions

Category 1: Provider Needs: Addressing Standards for Adoption and Use

Comment 1D. *In the context of APMs, consider developing partnerships with a diverse array of stakeholders (including providers and those representing beneficiary voices) to support development of standards and protections related to telehealth adoption, including workflow, patient privacy, care coordination, and service integration; team-based approaches; shifting to a culture of "routine access;" determining when telephone/audio-only access is appropriate; and establishing documentation requirements, including the interoperability of data gathered in the context of telehealth and needs related to cybersecurity.*

Research Questions

- *What is known about standards of care, quality measurement, safety, and appropriateness in the context of virtual versus in-person care?*
- *What are the best approaches for determining services where there should be payment parity between in-person and virtual care?*
- *How do we account for differences in the care environment and incentives inherent in virtual versus in-person care, while also maintaining simplicity and flexibility?*
- *Which telehealth interventions are different modalities/settings rather than new types of services?*
- *What program integrity challenges are associated with telehealth?*
- *How will the shift toward telehealth affect graduate medical education for both service delivery and training, as well as payments to support medical education?*

Addressing benchmarks and variation in standards by setting. As noted by stakeholders, it is important to find the right balance between virtual and in-person services to optimize care for individuals. Virtual services cannot fully substitute for in-person care, as some interventions are more difficult or impossible to provide virtually. In considering this balance, it is important to understand when telehealth service may add on to what is considered the usual standard of care versus times when telehealth is directly substituting for care that would have been delivered in-person. Stakeholders noted that payment parity between in-person and virtual care may be important to ensure access in some cases. However, in other cases, robust payment for virtual care may increase avoidable utilization or even raise program integrity concerns.

Given these issues, it is beneficial to consider fully integrating telehealth into comprehensive care models rather than including telehealth as a separate care “silo.” It is also important to adopt payment methods to ensure patients receive the most appropriate form of care. These methods should reduce the chance of inappropriate substitution of virtual care when in-person care is needed, but consider that current “site of service payment differentials” create incentives to deliver care in-person when virtual care may be appropriate. Finally, it is important to emphasize that these considerations may vary substantially depending on the type of service.

Telehealth does not currently have sufficient “guardrails,” including protections that would avert disparities in care, ensure appropriate use of virtual services, and ensure privacy and confidentiality. It is important to highlight the needs for standards of care, patient safety metrics, privacy procedures, and guidelines to address the appropriateness of in-person versus virtual care. It is particularly important to address patient privacy and confidentiality standards in the context of increased take-up of virtual behavioral health and substance use counseling. PTAC’s comments pertaining to addressing benchmarks and variation in telehealth standards by setting are included in Exhibit 4.

Exhibit 4: PTAC Comments

Category 1: Provider Needs: Addressing Benchmarks and Variation in Standards by Setting

Comment 1E. *Consider partnering with a diverse array of stakeholders (including providers and those representing beneficiary voices) to support development of standards for appropriate adoption of telehealth by setting; modified clinical quality measures for virtual versus in-person care; benchmarks using patient satisfaction measures to compare virtual care to in-person care; and use of analytic technology to enforce program integrity rules.*

Comment 1F. *Take into consideration policy issues such as efficacy of telehealth for various services; the types of providers that should be providing telehealth services; and the extent to which telehealth services substitute for, or complement existing services, especially in the context of different services (e.g., primary versus specialty care), providers (e.g., from physicians to community health workers), settings (e.g., home, office, or inpatient) and other issues (e.g., patient safety).*

Understanding provider and beneficiary costs. Rigorous cost accounting is needed to understand the cost of implementing telehealth, and variations in the cost of adoption by provider organization and geographic area. It is also important to understand the cost associated with important functions such as the use of staff to provide pre-visit testing, or the provision of real-time language translation as part of providing telehealth services. These concerns suggest the need for additional research to address these questions, noting that the

questions have implications for understanding investment costs and appropriate reimbursement in the context of APMs. PTAC's comments and research questions related to understanding both provider and beneficiary costs can be found in Exhibit 5.

Exhibit 5: PTAC Comments and Research Questions

Category 1: Understanding Provider and Beneficiary Costs

Comment 1G. *In the context of APMs, consider exploring interest in partnerships with a diverse array of stakeholders (including providers and those representing beneficiary voices) to support development of accurate methods to comprehensively account for costs of telehealth adoption and use for different provider types.*

Comment 1H. *In the context of APMs, consider doing research on costs associated with beneficiary access to broadband connectivity; technologies (e.g., tablets); coordinating care, language, and other communications-related services; and technical support needed to benefit from telehealth.*

Research Questions

- *How, if at all, should APMs incorporate the cost of implementation and effective use of telehealth into their payment design?*
- *How do different APM payment designs facilitate or create barriers to effective adoption and use of telehealth?*
- *What supports do beneficiaries receiving care through APMs need to most effectively benefit from telehealth?*
- *How does beneficiary satisfaction vary for specific services delivered virtually versus in-person?*

V.B. Category 2: Addressing Telehealth Barriers and Enablers: Policies Related to Access and Optimization

The second category of comments addresses policies that are related to optimizing the implementation of telehealth. This category of comments addresses some of the potential barriers and enablers of effective use of telehealth that were described earlier in this report.

Flexibility related to coverage and payment in the context of APMs. Barriers and enabling factors exist for telehealth adoption and use, including those that are geographic in nature. For example, state licensing requirements for clinical personnel can make it difficult to provide telehealth services across state lines. In addition, access to telehealth can vary across rural and urban settings, with more limited broadband access and infrastructure in rural settings.

Telephone-only modalities may be necessary to ensure access for some populations where infrastructure is more limited. In addition, telehealth can assist in addressing provider shortages

for services such as behavioral health treatment that can pose a barrier to access in both rural and urban areas.

Additional barriers to the use of telehealth have included limitations on the services that are covered, as well as limitations on covered sites of care for virtual care. The complexity of requirements for determining whether telehealth services are billable and uncertainty in coverage for virtual care have also represented barriers to its use.

The easing of geographic restrictions and the expansion of covered virtual services (for example, emergency medical screening) during the PHE increased access to telehealth services and reduced providers' and patients' exposure to COVID-19. For example, there has been an increase in hospital-at-home models during the PHE that will likely endure. These models will require specific types of monitoring for patients at home. Future telehealth payment policy will also need to address the issue of program complexity. The PHE has relaxed many restrictions on telehealth use that existed previously in part to ensure program integrity. However, it may be desirable to reinstitute some of these restrictions following the PHE to reduce financial risk and ensure patient safety. Exhibit 6 summarizes the Committee's comments and research questions on flexibility related to coverage and payment in the context of APMs.

Exhibit 6: PTAC Comments and Research Questions

Category 2: Barriers: Flexibility Related to Coverage and Payment in the Context of APMs

Comment 2A. *In the context of telehealth and APMs, consider flexibilities related to geography, site of care, covered services, and provider state licensing. Where possible, seek to provide greater certainty regarding reimbursement and coverage policy for telehealth under APMs during and following the PHE.*

Comment 2B. *Consider opportunities related to integrating telehealth into APMs and PFPMs to ensure that these services are used appropriately without inappropriately increasing Medicare spending, and aggravating integrity-related risks.*

Research Questions

- *Which options for home monitoring are optimal without adding costs?*
- *How do we best train the workforce for home-based care?*

Future research on enabling patient monitoring and other interventions. In the context of enabling greater use of remote patient monitoring and other telehealth interventions, future research may be informative. For example, research on telehealth utilization among populations with chronic diseases can highlight patients' and providers' decisions on whether and when to seek and/or provide virtual care. Patients with chronic diseases often view being symptomatic as normal or expected and may not seek virtual and/or in-person services that can

help to avoid hospitalizations, ED visits, or adverse health outcomes. Different telehealth technologies imply that access and barriers will differ based on modality and technical requirements; an understanding of these barriers and how they differ across modalities and for different populations is likely to assist in accelerating telehealth utilization.

Additionally, although telehealth research advanced rapidly during the PHE, research that considers services that are not addressed by the current PHE will be important to inform long-term policy approaches. Telehealth services that are not related to virtual event care, such as remote patient monitoring, can provide proactive care. These services are not addressed through the temporary 1135 PHE waivers, but could be an important strategy in care delivery for certain patients in the future. PTAC's comments related to future research on opportunities such as data sharing, reducing fragmentation, enabling patient monitoring, and other interventions are included in Exhibit 7.

Exhibit 7: PTAC Comments

Category 2: Enablers: Future Research on Enabling Patient Monitoring and Other Interventions

Comment 2C. *Consider investigating in ways/opportunities that enable data sharing without added burden, mitigating the development of new data silos, and perpetuating care fragmentation, such as may occur with the emergence of free-standing telehealth companies.*

Comment 2D. *In the context of new and existing APMs, consider further research that could assess the potential of adopting remote patient monitoring and other forms of telehealth (in new or existing models) not related to existing temporary waivers during and after the PHE.*

V.C. Category 3: Addressing Payment Issues: Paying for Telehealth under PFPs or APMs

This section focuses on payment issues relating to telehealth, which could serve as the biggest barrier to or largest accelerant for increased adoption of telehealth in care delivery. Telehealth requires considerable infrastructure investments; as these investments are made, it is important to have an appropriate payment structure that supports telehealth service delivery. APMs represent a promising opportunity for supporting flexibility in using and evaluating telehealth services while addressing potential concerns about program integrity.

Document emerging findings. As the state of knowledge on telehealth advances during and after the COVID-19 PHE, it is important to document emerging findings to assist in guiding future payment policy. In particular, having an understanding of how payment for telehealth intersects with APMs will be useful for future model development and care delivery. For example, providers engaged in APMs were able to quickly adapt to providing increased virtual care during the PHE. In addition, APMs may give providers more flexibility (sometimes through prospective and risk-adjusted payments) to adopt virtual care modalities. There may be

additional insights from the experience of APMs that can be used for identifying best practices in telehealth deployment for a range of clinical scenarios and provider types. Exhibit 8 includes PTAC’s comment and research question related to documenting emerging findings.

Exhibit 8: PTAC Comment and Research Question

Category 3: Document Emerging Findings

Comment 3A. *Consider highlighting best practices and findings from rapid adoption of telehealth among providers involved in APMs across provider setting and clinical scenarios (e.g., stand-alone substance use disorder [SUD] or behavioral health, as well as usual source of care).*

Research Question

- *How does the role of telehealth vary if the intervention is a substitute for in-person care versus a complement or supplement to in-person care?*

Use APMs to enable telehealth. As Medicare payments for telehealth shift from the PHE to a longer-term approach, program integrity will be an important consideration for ensuring that the increased use of telehealth does not generate unnecessary spending. Building telehealth into APMs and PFPMs may be one approach for helping to ensure that services are used appropriately and do not result in overspending. Flexibility that is afforded through prospective payments and risk-adjustment can help to support flexible adoption of virtual care modalities.

Virtual care delivered under APMs can be a tool for helping to ensure continuity of care, avoid exposure to health risks, reduce avoidable service utilization (ED and inpatient), and support provider-to-provider coordination – both during the PHE and more generally. In the future, additional evidence will be needed to assess the impact of telehealth on cost, access, and quality for various services.

One issue in telehealth payment is whether telehealth visits are supplementing or replacing in-person care, a distinction that is difficult to measure in a fee-for-service (FFS) environment. Therefore, implementation of telehealth in an APM or PFPM context may be critical for identifying the extent to which certain services are substitutes or supplements to in-person care. PTAC’s comments and research questions regarding the use of APMs to enable telehealth are listed in Exhibit 9.

Exhibit 9: PTAC Comments and Research Questions

Category 3: Use APMs to Enable Telehealth

Comment 3B. *Consider including telehealth modalities across all APMs currently in testing or development as tools for facilitating access to care; optimizing care delivery; reducing avoidable inpatient or ED care; improving health outcomes; improving provider coordination; supporting provider teaching, education, and collaboration; and helping to avoid fraud and ensure program integrity.*

Comment 3C. *Consider using Accountable Care Organizations (ACOs) or other models to assist in testing the impact of telehealth on cost, access, and quality for various services.*

Research Questions

- *How should coverage and reimbursement rules vary for these different forms of telehealth?*
- *What are the reasons for and against the inclusion of telehealth in different types of payment models?*
- *What are the best approaches to understanding the true cost of adopting different telehealth modalities?*
- *What are the models of payment that will make these financial investments feasible?*

Leverage insights from previous PTAC proposals. A number of previous PTAC proposals included telehealth as a component of their proposed models. The approaches to telehealth that were described in previous PTAC proposals can provide insights for future model development. Some proposed models included innovative care delivery models related to providing remote assessment and education to rural providers relating to neurological conditions; telemonitoring of patients with chronic conditions; providing team-based care to multiple skilled nursing facilities; ensuring care coordination after discharge from EDs; and maximizing primary care provider flexibility.

Previous PTAC proposals also highlight ways in which innovative and flexible alternative payment approaches can support telehealth adoption. For example, shared savings can potentially be used to support cost-saving telehealth interventions. Several PTAC proposals feature a prospective payment for proposed care delivery activities. However, these proposals have not tended to consider two-sided risk based on total cost of care, because the proposals' focus tends to be on a single condition treated by a specialist. PTAC's comment on leveraging insights from previous PTAC proposals is included in Exhibit 10.

Exhibit 10: PTAC Comment

Category 3: Leverage Insights From Previous PTAC Proposals

Comment 3D. *Review previous PTAC proposals that included a telehealth component, and consider incorporating some of the telehealth-related elements from one or more of these proposals into ACOs and other Center for Medicare & Medicaid Innovation (CMMI) models (especially models that include prospective payment and two-sided risk) in order to pilot test potential best practices and assess their impact on health care costs and quality.*

VI. CONCLUSIONS

This report highlights key comments and research questions stemming from PTAC’s work on the topic of telehealth in APMs and PFPMs. Services or interventions involving telehealth vary considerably, and effective use of telehealth will vary depending on beneficiary characteristics and clinical scenarios. The rapid shift to telehealth services during the COVID-19 PHE has highlighted the potential for telehealth to play an important role in optimizing health care for Medicare beneficiaries. PTAC has identified some issues and research questions related to optimizing telehealth’s ability to fulfill this role within the context of value-based health care, which are included in this report.

PTAC believes that many promising opportunities exist to optimize health care delivery through telehealth. At the same time, PTAC acknowledges that many potential challenges arise with the increased use of telehealth, including variation in beneficiary access, infrastructure requirements, and payment concerns. APMs could provide an important framework for the innovation that is needed to overcome potential risks and barriers associated with telehealth use. Particular features needing attention include supporting infrastructure costs and establishing incentives for appropriate, equitable, and cost-effective adoption of telehealth. APMs can also provide a promising avenue for supporting the flexible use and evaluation of telehealth services in ways that maintain program integrity and avoid fraud and abuse.

PTAC would be pleased to work with the Secretary to determine ways in which the information contained in this report might be utilized to ensure that the post-PHE implementation of telehealth will work to the advantage of the Medicare program and its beneficiaries. In particular, PTAC would draw on its experience and that of its stakeholders, including review of future proposals, to help to inform the incorporation of telehealth within APMs and PFPMs.

APPENDIX 1. COMMITTEE MEMBERS AND TERMS

Jeffrey Bailet, MD, Chair

Paul Casale, MD, MPH, Vice Chair

Term Expires October 2021

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Kavita K. Patel, MD, MSHS

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Camden Coalition of Healthcare Providers*

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APPENDIX 2. CHARACTERISTICS OF PTAC PROPOSALS WITH A TELEHEALTH COMPONENT, DECEMBER 2016 - MARCH 2020

Submitter and Proposal	Telehealth Modality	Clinical Focus, Provider Type, and Place of Service	Care Delivery and Payment Model Objectives
Proposals with telehealth as a central feature of the proposed model			
<ul style="list-style-type: none"> Avera Health Intensive Care Management in Skilled Nursing Facility Alternative Payment Model (ICM SNF APM) 	<ul style="list-style-type: none"> Synchronous (live-video, telephone); Asynchronous 	<ul style="list-style-type: none"> Clinical Focus: SNFs and NFs Provider: Geriatrician Care Teams for SNFs and NFs Place of Service: SNFs and NFs 	<ul style="list-style-type: none"> Improve access to care; provide enhanced and/or 24/7 access to care; improve quality of care and associated health outcomes; reduce avoidable and costly ED visits and hospitalizations
<ul style="list-style-type: none"> Illinois Gastroenterology Group and SonarMD Project Sonar 	<ul style="list-style-type: none"> Synchronous (telephone); mHealth; Remote Patient Monitoring 	<ul style="list-style-type: none"> Clinical Focus: Crohn's disease Provider: Gastroenterology practices Place of Service: Patient home 	<ul style="list-style-type: none"> Improve access to care; improve patient engagement; reduce avoidable and costly ED visits and inpatient utilization
<ul style="list-style-type: none"> Pulmonary Medicine, Infectious Disease and Critical Care Consultants Medical Group (PMA) The COPD and Asthma Monitoring Project 	<ul style="list-style-type: none"> Synchronous (live-video, telephone); mHealth; Remote Patient Monitoring 	<ul style="list-style-type: none"> Clinical Focus: COPD and/or asthma Provider: Pulmonology physicians Place of Service: Patient home 	<ul style="list-style-type: none"> Improve access to care; reduce avoidable and costly ED visits and inpatient utilization; provide payments for remote monitoring
<p>Eitan Sobel, MD</p> <p>Remote specialists and experts on demand improving care and saving costs (Revised version)</p>	<ul style="list-style-type: none"> Synchronous (live-video, telephone); Remote Patient Monitoring 	<ul style="list-style-type: none"> Clinical Focus: Not specified Provider: Regional Referral Centers (specialists); remote specialists "for most health issues at any level of care and at any geographic location"* Place of Service: Not specified 	<ul style="list-style-type: none"> Improve access to care/quality of specialist care in rural/remote areas; improve care coordination and delivery, and patient choice; reduce avoidable and costly transfers, ED visits, and hospitalizations
<ul style="list-style-type: none"> University of New Mexico Health Sciences Center ACCESS Telemedicine: An Alternative Healthcare Delivery Model for Rural Cerebral Emergencies 	<ul style="list-style-type: none"> Synchronous (live-video) 	<ul style="list-style-type: none"> Clinical Focus: Cerebral emergencies Provider: Neurologists and neurosurgeons; providers in rural and community hospitals Place of Service: Inpatient; outpatient; or emergency department in rural/ community hospital 	<ul style="list-style-type: none"> Improve access to care/quality of specialist care in rural/remote areas; provide enhanced and/or 24/7 access to care; improve quality of care and associated health outcomes; reduce avoidable and costly transfers and patient travel; improve financial viability of rural and community hospitals

Submitter and Proposal	Telehealth Modality	Clinical Focus, Provider Type, and Place of Service	Care Delivery and Payment Model Objectives
Proposals with telehealth as an aspect of the proposed care delivery and/or payment model			
<ul style="list-style-type: none"> American Academy of Hospice and Palliative Medicine (AAHPM) Patient and Caregiver Support for Serious Illness (PACSSI) 	<ul style="list-style-type: none"> Synchronous (live-video, telephone); Remote Patient Monitoring 	<ul style="list-style-type: none"> Clinical Focus: Serious illness and palliative care Provider: Palliative care teams Place of Service: Inpatient; outpatient; other palliative care settings 	<ul style="list-style-type: none"> Improve access to care; provide enhanced and/or 24/7 access to care; improve quality of care and associated health outcomes; provide payments for remote monitoring
<p>American Academy of Neurology (AAN) The Patient-Centered Headache Care Payment (PCHCP)</p>	<ul style="list-style-type: none"> Synchronous (live-video, telephone); Asynchronous; mHealth; Remote Patient Monitoring; 	<ul style="list-style-type: none"> Clinical Focus: Migraines or recurrent/complex headache disorders Provider: Primary care providers; neurologists; physicians with headache care expertise Place of Service: Inpatient; outpatient in primary care; patient home 	<ul style="list-style-type: none"> Improve access to care/quality of specialist care in rural/remote areas; improve care coordination and delivery, and patient choice; reduce avoidable and costly ED visits and hospitalizations
<ul style="list-style-type: none"> American College of Emergency Physicians Acute Unscheduled Care Model (AUCM): Enhancing Appropriate Admissions 	<ul style="list-style-type: none"> Synchronous (telephone); Modality not Specified 	<ul style="list-style-type: none"> Clinical Focus: Patients discharged home from ED and in a care transition Provider: ED physician; Part B provider Place of Service: Patient home 	<ul style="list-style-type: none"> Improve quality of care and associated health outcomes; improve care coordination and delivery, and patient choice; reduce avoidable and costly ED visits
<p>Coalition to Transform Advanced Care (C-TAC) Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model</p>	<ul style="list-style-type: none"> Synchronous (live-video, telephone); mHealth 	<ul style="list-style-type: none"> Clinical Focus: Serious illness and palliative care Provider: Advanced Care Model (ACM) care team Place of Service: Patient home 	<ul style="list-style-type: none"> Improve access to care; improve care coordination and delivery, and patient choice
<p>Hackensack Meridian Health (HMH) and Cota Inc. (HMH/Cota) Oncology Bundled Payment Program Using CAN-Guided Care</p>	<ul style="list-style-type: none"> Mobile Health; Modality not Specified 	<ul style="list-style-type: none"> Clinical Focus: Breast, colon, rectal, or lung cancer Provider: Eligible professionals in HMH system Place of Service: Patient home 	<ul style="list-style-type: none"> Improve access to care; improve quality of care and associated health outcomes; improve care coordination and delivery, and patient choice
<ul style="list-style-type: none"> Innovative Oncology Business Solutions Making Accountable Sustainable Oncology Networks (MASON) 	<ul style="list-style-type: none"> Synchronous (telephone); mHealth; Modality not Specified 	<ul style="list-style-type: none"> Clinical Focus: Cancer Provider: National Cancer Care Alliance (NCCA) oncology physicians Place of Service: Patient home 	<ul style="list-style-type: none"> Improve access to care; provide enhanced and/or 24/7 access to care; improve quality of care and associated health outcomes

Submitter and Proposal	Telehealth Modality	Clinical Focus, Provider Type, and Place of Service	Care Delivery and Payment Model Objectives
<p>Icahn School of Medicine at Mount Sinai (Mount Sinai) HaH Plus (Hospital at Home Plus) Provider-Focused Payment Model</p>	<ul style="list-style-type: none"> • Synchronous (live-video, telephone) 	<ul style="list-style-type: none"> • Clinical Focus: Acute illness/exacerbated chronic disease • Provider: Physicians; HaH-Plus providers • Place of Service: Patient home 	<ul style="list-style-type: none"> • Improve quality of care and associated health outcomes; improve care coordination and delivery, and patient choice; reduce avoidable and costly hospitalizations
<p>New York City Department of Health and Mental Hygiene (NYC-DOHMH) Multi-provider, bundled episode of care payment model for treatment of chronic hepatitis C virus (HCV) using care coordination by employed physicians in hospital outpatient clinics</p>	<ul style="list-style-type: none"> • Synchronous (live-video); mHealth 	<ul style="list-style-type: none"> • Clinical Focus: Hepatitis C virus • Provider: Primary care physicians; specialists, nurse practitioners; other health care staff • Place of Service: Primary care and specialty practices 	<ul style="list-style-type: none"> • Improve access to care; improve care coordination and delivery, and patient choice
<p>Personalized Recovery Care (PRC) Home Hospitalization: An Alternative Payment Model for Delivering Acute Care in the Home</p>	<ul style="list-style-type: none"> • Synchronous (live-video, telephone); Optional mHealth; Remote Patient Monitoring 	<ul style="list-style-type: none"> • Clinical Focus: Acute illness / exacerbated chronic disease in patient home • Provider: Admitting physician; on-call physician; recovery care coordinator • Place of Service: Patient home 	<ul style="list-style-type: none"> • Provide enhanced and/or 24/7 access to care; improve quality of care and associated health outcomes; improve care coordination and delivery, and patient choice; reduce avoidable and costly hospitalizations; provide payments for remote monitoring
<p>Proposals with telehealth as an optional component and/or potential for adoption of telehealth under the proposed model</p>			
<p>American Academy of Family Physicians (AAFP) Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care</p>	<ul style="list-style-type: none"> • Synchronous (telephone) 	<ul style="list-style-type: none"> • Clinical Focus: Primary care patients • Provider: Primary care providers • Place of Service: Patient home 	<ul style="list-style-type: none"> • Improve access to care; improve care coordination and delivery, and patient choice
<p>Jean Antonucci, MD An Innovative Model for Primary Care Office Payment</p>	<ul style="list-style-type: none"> • Synchronous (telephone); Modality not Specified 	<ul style="list-style-type: none"> • Clinical Focus: Primary care patients • Provider: Primary care physicians and independent care nurse practitioners • Place of Service: Patient home 	<ul style="list-style-type: none"> • Improve access to care; improve care coordination and delivery, and patient choice

Submitter and Proposal	Telehealth Modality	Clinical Focus, Provider Type, and Place of Service	Care Delivery and Payment Model Objectives
Community Oncology Alliance (COA) Oncology Care Model 2.0	<ul style="list-style-type: none"> • Synchronous (live-video, telephone); Remote Patient Monitoring; Modality not Specified 	<ul style="list-style-type: none"> • Clinical Focus: Cancer • Provider: Medical oncologists • Place of Service: Patient home 	<ul style="list-style-type: none"> • Improve access to care; provide enhanced and/or 24/7 access to care
Seha Medical and Wound Care Bundled Payment for All Inclusive Outpatient Wound Care Services in Non Hospital Based Setting	<ul style="list-style-type: none"> • Synchronous (live-video, telephone); Modality not Specified 	<ul style="list-style-type: none"> • Clinical Focus: Acute and/or chronic wound • Provider: Office-based outpatient wound care • Place of Service: Patient home 	<ul style="list-style-type: none"> • Improve care coordination and delivery, and patient choice; reduce avoidable and costly hospitalizations

* The Sobel proposal does not specify any clinical settings, but seeks to provide remote care at all levels of care.

APPENDIX 3. ADDITIONAL RESOURCES RELATED TO PTAC’S THEME-BASED DISCUSSION ON OPTIMIZING TELEHEALTH IN ALTERNATIVE PAYMENT MODELS AND PHYSICIAN-FOCUSED PAYMENT MODELS

The following is a summary of additional resources related to PTAC’s theme-based discussion on optimizing telehealth in Alternative Payment Models (APMs) and physician-focused payment models (PFPMs), which are publicly available on the ASPE PTAC website at the links that are provided below.

Environmental Scans and Reports

[Environmental Scan on Telehealth in the Context of APMs and PFPMs](#)

[Telehealth Environmental Scan Supplement](#)

[Overview & Summary of September 2020 Physician-Focused Payment Model Technical Advisory Committee \(PTAC\) Public Meeting Discussions on Telehealth](#)

Note: Summaries of Discussions with Previous PTAC Submitters and a Next Generation Accountable Care Organization will be posted in Summer 2021 on the [PTAC Resources Page](#).

Request for Input (RFI)

[Request for Public Input on PTAC’s Review of Telehealth and PFPMs](#)

[Public Input on PTAC’s Review of Telehealth and PFPMs](#)

Materials from Public Meetings

[September 16, 2020, Presentation: An Overview of Proposals Submitted to the Physician-Focused Payment Model Technical Advisory Committee \(PTAC\) That Included Telehealth Components, as of March 2020](#)

[September 16, 2020, Panelist Biographies](#)

[September 16, 2020, Panelist Questions](#)

[Key Themes and Potential Comments Regarding Telehealth in the Context of APMs Based on the Telehealth Theme-Based Discussion During the September 16, 2020, Public Meeting](#)

[December 8, 2020, Presentation: Public Input Informing PTAC’s Review of Telehealth and PFPMs](#)

[December 8, 2020, Presentation: Telehealth Preliminary Comments Development Team Findings](#)

Other Information Related to Public Meetings

[September 16, 2020, Public Meeting Minutes](#)

[September 16, 2020, Public Meeting Transcript](#)

[December 8, 2020, Public Meeting Minutes](#)

APPENDIX 4. SUMMARY OF PTAC COMMENTS ON OPTIMIZING TELEHEALTH IN THE CONTEXT OF ALTERNATIVE PAYMENT MODELS AND PHYSICIAN-FOCUSED PAYMENT MODELS

The Committee’s comments have been summarized in the following broad topic areas:

- Category 1: Addressing Telehealth Infrastructure: Provider and Beneficiary Needs
- Category 2: Addressing Telehealth Barriers and Enablers: Policies Related to Access and Optimization
- Category 3: Payment Issues: Paying for Telehealth under PFPs or APMs

Category 1: Addressing Telehealth Infrastructure: Provider and Beneficiary Needs	
Beneficiary Needs: Avoid Disparities and Focus on Vulnerable Populations	
1A	Consider sponsoring a report on unintended consequences associated with widespread adoption and use of telehealth that addresses the exacerbation of disparities in care for specific populations due to the digital divide, language/communication needs, cognitive and physical impairments, and long-term services and supports (LTSS) needs; and for those living in the community with limited caregiver support.
1B	Consider partnering with a diverse array of stakeholders (including providers and those representing beneficiary voices) on development of standards for adoption of telehealth to address LTSS needs of community-dwelling populations and to address the impact of social isolation.
1C	Consider further research on unintended consequences of widespread use of telehealth: address disparities in care for specific populations, including those with impairments or those who require language translation and culturally competent education.
Provider Needs: Address Standards for Adoption and Use	
1D	In the context of APMs, consider developing partnerships with a diverse array of stakeholders (including providers and those representing beneficiary voices) to support development of standards and protections related to telehealth adoption, including workflow, patient privacy, care coordination, and service integration; team-based approaches; shifting to a culture of “routine access;” determining when telephone/audio-only access is appropriate; and establishing documentation requirements, including the interoperability of data gathered in the context of telehealth and needs related to cybersecurity.
Provider Needs: Address Benchmarks and Variation in Standards by Setting	
1E	Consider partnering with a diverse array of stakeholders (including providers and those representing beneficiary voices) to support development of standards for appropriate adoption of telehealth by setting; modified clinical quality measures for virtual versus in-person care; benchmarks using patient satisfaction measures to compare virtual care to in-person care; and use of analytic technology to enforce program integrity rules.

Category 1: Addressing Telehealth Infrastructure: Provider and Beneficiary Needs	
1F	Take into consideration policy issues such as efficacy of telehealth for various services; the types of providers that should provide telehealth services; and the extent to which telehealth services are a substitute for, or a complement to existing services, especially in the context of different services (e.g., primary versus specialty care), providers (e.g., from physicians to community health workers), settings (e.g., home, office, or inpatient) and other issues (e.g., patient safety).
Understanding Provider and Beneficiary Costs	
1G	In the context of APMs, consider exploring interest in partnerships with a diverse array of stakeholders (including providers and those representing beneficiary voices) to support development of accurate methods to comprehensively account for costs of telehealth adoption and use for different provider types.
1H	In the context of APMs, consider doing research on costs associated with beneficiary access to broadband connectivity; technologies (e.g., tablets); coordinating care, language, and other communications-related services; and technical support needed to benefit from telehealth.

Category 2: Addressing Telehealth Barriers and Enablers: Policies Related to Access and Optimization	
Barriers: Flexibility Related to Coverage and Payment in the Context of APMs	
2A	In the context of telehealth and APMs, consider flexibilities related to geography, site of care, covered services, and provider state licensing. Where possible, seek to provide greater certainty regarding reimbursement and coverage policy for telehealth under APMs during and following the PHE.
2B	Consider opportunities related to integrating telehealth into APMs and PFPMs to ensure that these services are used appropriately without inappropriately increasing Medicare spending, and aggravating program integrity-related risks.
Enablers: Consider Future Research on Opportunities such as Data Sharing, Reducing Fragmentation, and Enabling Patient Monitoring and Other Interventions	
2C	Consider investigating in ways/opportunities that enable data sharing without added burden, mitigating the development of new data silos, and perpetuating care fragmentation, such as may occur with the emergence of free-standing telehealth companies.
2D	In the context of new and existing APMs, consider further research that could assess the potential of adopting remote patient monitoring and other forms of telehealth (in new or existing models) not related to existing temporary waivers during and after the PHE.

Category 3: Addressing Payment Issues: Paying for Telehealth under PFPMs or APMs	
Document Emerging Findings	
3A	Consider highlighting best practices and findings from rapid adoption of telehealth among providers involved in APMs across provider setting and clinical scenarios (e.g., stand-alone substance use disorder [SUD] or behavioral health, as well as usual source of care).

Category 3: Addressing Payment Issues: Paying for Telehealth under PFPMs or APMs	
Use APMs to Enable Telehealth	
3B	Consider including telehealth modalities across all APMs currently in testing or development as tools for facilitating access to care; optimizing care delivery; reducing avoidable inpatient or ED care; improving health outcomes; improving provider coordination; supporting provider teaching, education, and collaboration; and helping to avoid fraud and ensure program integrity.
3C	Consider using ACOs or other models to assist in testing the impact of telehealth on cost, access, and quality for various services.
Leverage Insights From Previous PTAC Proposals	
3D	Review previous PTAC proposals that included a telehealth component, and consider incorporating some of the telehealth-related elements from one or more of these proposals into ACOs and other CMMI models (especially models that include prospective payment and two-sided risk) in order to pilot test potential best practices and assess their impact on health care costs and quality.

ⁱ U. S. Department of Health and Human Services. *Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus*. January 31, 2021.

<https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx>

ⁱⁱ Telehealth Programs. Official website of the U.S. Health Resources & Services Administration. Published April 28, 2017. Accessed July 8, 2020. <https://www.hrsa.gov/rural-health/telehealth><https://www.hrsa.gov/rural-health/telehealth>

ⁱⁱⁱ Telehealth Programs. Official website of the U.S. Health Resources & Services Administration. Published April 28, 2017. Accessed July 8, 2020. <https://www.hrsa.gov/rural-health/telehealth><https://www.hrsa.gov/rural-health/telehealth>

^{iv} Marcoux RM, Vogenberg FR. Telehealth: Applications From a Legal and Regulatory Perspective. *P T*. 2016;41(9):567-570.

^v Bosworth A, Ruhter J, Samson LW, et al. *ASPE Issue Brief: Medicare Beneficiary Use of Telehealth Visits: Early Data From the Start of the COVID-19 Pandemic*; 2020. Accessed August 4, 2020. <https://aspe.hhs.gov/pdf-report/medicare-beneficiary-use-telehealth>

^{vi} Bosworth A, Ruhter J, Samson LW, et al. *ASPE Issue Brief: Medicare Beneficiary Use of Telehealth Visits: Early Data From the Start of the COVID-19 Pandemic*; 2020. Accessed August 4, 2020. <https://aspe.hhs.gov/pdf-report/medicare-beneficiary-use-telehealth>

^{vii} Lonergan PE, Washington SL, Branagan L, et al. Rapid Utilization of Telehealth in a Comprehensive Cancer Center as a Response to COVID-19: Cross-Sectional Analysis. *Journal of Medical Internet Research*. 2020; 22(7). <https://www.jmir.org/2020/7/e19322/>

^{viii} Ateev Mehrotra et al., *The Impact of the COVID-19 Pandemic on Outpatient Care: Visits Return to Prepandemic Levels, but Not for All Providers and Patients*. Commonwealth Fund, Oct. 2020. <https://doi.org/10.26099/41xy-9m57>

^{ix} Centers for Medicare & Medicaid Services, *Coronavirus waivers & flexibilities*. <https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers>