

Physician-Focused Payment Model Technical Advisory Committee

Preliminary Review Team Report to the Physician-Focused Payment Model Technical Advisory Committee on *ACCESS Telemedicine: An Alternative Healthcare Delivery Model for Rural Cerebral Emergencies*

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Physician-focused payment model (PFPM) proposals submitted to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) in accordance with PTAC’s proposal submission instructions are assigned to a preliminary review team (PRT). Each PRT prepares a report of its findings on the proposal for discussion by the full PTAC. The report is not binding on PTAC; PTAC may reach different conclusions from those contained in the report. Each report and related materials are available on the PTAC section of the Office of the Assistant Secretary for Planning and Evaluation (ASPE) [website](#).

A. Proposal Information

- 1. Proposal Name:** ACCESS Telemedicine: An Alternative Healthcare Delivery Model for Rural Cerebral Emergencies
- 2. Submitting Organization or Individual:** The University of New Mexico Health Sciences Center (UNMHSC)
- 3. Submitter’s Abstract:**

“There is a significant unmet need for cerebral emergent care in rural/underserved America. This is due to paucity of providers nationally and lack of financial resources in rural hospitals to support current telemedicine models of payment. Our preliminary work addressing this growing healthcare challenge has focused on New Mexico (NM), a state with a third of the population living in rural or underserved areas without immediate geographic access to cerebral specialists. Critical care and rapid decision making for emergency cerebral conditions are imperative and time-sensitive to maximize patient outcomes in these populations. Rural and underserved community hospitals cannot employ full time neuro specialists. In the current care model, emergency room physicians are often ill prepared to diagnose and treat these

patients. As a result, most patients with this spectrum of disorders are transferred to a tertiary care facility for further evaluation and treatment. This current model driven by geographic healthcare disparity negatively impacts patient outcomes driven by timely treatments, healthcare economics, and care delivery experience.

During the last four years our team designed, developed and implemented an efficient and successful rural hospital neuro-emergent telemedicine platform and payment model (ACCESS) under a Centers for Medicare and Medicaid Innovation (CMMI) award. We successfully implemented telemedicine in rural NM to greatly enhance local care, achieving the Triple Aim of improved care, decreased costs, and improved experience. This highly successful program has met and exceeded clinical and financial savings outcomes. However, the team discovered inadequate reimbursement options at any level through private and public insurers to sustain this program for enrolled hospitals or to expand and scale the program to other specialties. Therefore, the team began working with NM State Medicaid and Managed Care Organizations to develop a bundled payment methodology that would work with public and private insurers. On January 1, 2019 the NM Medicaid Office included ACCESS Telemedicine in their Physician Health Fee Schedule for a bundled payment using modifiers to distinguish between Neurology and Neurosurgery consults. The next, critical step toward complete sustainability of the program is a new, alternative physician focused payment model for Medicare patients.

An innovative, alternative payment model (APM) that only charges for consulting services when needed is ideal for rural hospitals that may only have an emergent need a few times per week/month. As demonstrated in our ongoing model deployment in the NM ACCESS program, these consulting services can be effectively provided remotely through telemedicine. Cloud based technology has removed the need for geographic proximity and increased the pool of specialists that can rapidly provide neuro emergent care and triage. All stakeholders effectively engaged with the technology to maximize patient care and reduce costs, and all provided high levels of user satisfaction with the technology and program model. While our model initially focused on small, rural spoke hospitals, we quickly discovered that the model also applied to hospitals that were not typically classified as rural, but similarly experience shortages of neurological specialists.

Several elements are essential for the ACCESS model to be effective including physician specialist consulting time, telemedicine technology, infrastructure, and education/training of spoke hospital providers. A single bundled payment code with modifiers as prescribed by NM Medicaid in its guidance document is sufficient to cover all essential elements, i.e. professional services, training and technology that significantly simplifies billing for spoke hospitals and reduces administrative overhead. The contents of this submission address ACCESS Telemedicine model specifics and data to date in support of the proposed APM, which would have significant continued benefit in NM, and has the potential to be scaled to underserved communities across the U.S.”

B. Summary of the PRT Review

The UNMHSC proposal was received by PTAC on February 13, 2019. The PRT conducted its review of the proposal between March 27, 2019, and August 9, 2019. The PRT's findings are summarized in the table below.

PRT Rating of Proposal by Secretarial Criteria

Criteria Specified by the Secretary (at 42 CFR § 414.1465)	PRT Rating	Unanimous or Majority Conclusion
1. Scope (High Priority)	Meets Criterion and Deserves Priority Consideration	Unanimous
2. Quality and Cost (High Priority)	Meets Criterion and Deserves Priority Consideration	Unanimous
3. Payment Methodology (High Priority)	Meets Criterion	Unanimous
4. Value over Volume	Meets Criterion and Deserves Priority Consideration	Unanimous
5. Flexibility	Meets Criterion	Unanimous
6. Ability to Be Evaluated	Meets Criterion	Unanimous
7. Integration and Care Coordination	Meets Criterion	Unanimous
8. Patient Choice	Meets Criterion	Unanimous
9. Patient Safety	Meets Criterion	Unanimous
10. Health Information Technology	Meets Criterion	Unanimous

C. Information Reviewed by the PRT

1. Proposal and Additional Information Provided by the Submitter

The PRT reviewed the UNMHSC proposal as well as additional information provided by the submitter in response to two sets of written questions.

Proposal Summary

The ACCESS Telemedicine proposal aims to expand access to neurological and neurosurgical expertise in rural and underserved areas through telemedicine. More specifically, ACCESS Telemedicine is a two-way audiovisual program that connects providers in rural and underserved areas to neurology and neurosurgical experts to assist in evaluating patients presenting with cerebral emergencies. Rapid decision-making and timely initiation of treatment are critical for neurological emergencies. In areas lacking specialists trained in neurology, patients presenting for cerebral emergencies are often transferred to tertiary care facilities for evaluation and treatment, which can be costly and lead to delays in care. By connecting providers in rural and underserved hospitals to neurological specialists, ACCESS Telemedicine has been able to reduce transfers and improve timeliness of care.

Under the ACCESS Telemedicine model, providers may request a consultation with either a neurologist or neurosurgeon using an online platform. The system then

connects them with an available specialist who, using a telemedicine platform, provides consultation on the case. Specialists are able to view digitally transferred imaging and conduct verbal or visual assessment using audio or video conferencing. The consulting physician provides recommendations on treatment to the requesting provider who ultimately decides on a course of action for caring for the patient. The requesting provider can, at no additional cost, have a follow-up consultation on the same case within 24 hours. All other health care services provided to the patient, outside of the telehealth consultation, are billed through existing mechanisms.

The ACCESS Telemedicine program began as a CMMI Health Care Innovation Award (HCIA). Under HCIA, UNMHSC developed and implemented the ACCESS Telemedicine model with 17 hospitals in New Mexico. Beginning January 2019, the New Mexico Medicaid program implemented the ACCESS bundled payment system, with modifiers for neurology versus neurosurgery consultations. The submitter also indicates it is working with other health care payers, including Medicare Advantage plans, to incorporate the ACCESS Telemedicine bundle into their covered services.

Although traditional Medicare (fee-for-service, or FFS) covers telemedicine services, the proposal indicates that Medicare telehealth reimbursement is insufficient to cover the full cost of delivering services for rural cerebral emergencies, particularly the underlying technology platform costs. Under current Medicare provisions,ⁱ Medicare telehealth payment to distant-site physicians for consultations provided to patients in an originating site emergency department (ED) or initial inpatient assessment depend on the length of consultation: G0425 for 30 minutes, G0426 for 50 minutes, or G0427 for 70 minutes (at CY2019 Medicare Fee Schedule national average facility rates of \$101.27, \$137.67, or \$204.35, respectively). The same payment is made to the distant-site consulting physician regardless of specialty (e.g., neurologist versus neurosurgeon). The rural originating site hospital receives a small payment (approximately \$27 in CY2019) to cover costs to the originating site for the telemedicine services.

The ACCESS Telemedicine model proposes an alternative, a bundled payment for Medicare patients with neuro-emergent conditions. Under the ACCESS Telemedicine proposal, rural hospitals that serve as the originating site would receive a bundled payment when using neurology or neurosurgical telehealth consults from distant site practitioners. The bundled payment would include the cost of the consult, technology, staff education, and quality assurance. The rural hospital would be responsible for paying the distant site neurologist or neurosurgeon and the telemedicine technology provider. The ACCESS Telemedicine proposal currently uses the Net Medical Express (NMXS) platform to provide the audiovisual hardware, call center, and network infrastructure to connect remote hospitals to expert neurologists and neurosurgeons. The proposal notes that other providers besides NMXS could develop and offer this service.

In contrast to current Medicare payment methodology, the ACCESS Telemedicine program payments differ by the consulting provider specialty and include not only the payment to the consulting provider but also payment for the technology platform (\$175 regardless of physician specialty) and a residual payment, as shown in Table 1 below. Submitter documents describe the use of a “fair market value” approach to determine the payments to the consulting physician. The residual payment initially is made to the rural hospital, which then disburses the money to cover the total costs of the provided services, including covering an on-call payment for neurosurgeon support (\$100 per day, with one or two neurosurgeons currently participating) and other educational and administrative support costs to maintain the ACCESS Telemedicine program.

Table 1: UNMHSC Proposed Payments by Provider Type

Proposed Payments	Provider Type: Neurologist	Provider Type: Neurosurgeon
Total Charge per Consult (sum of components below)	\$850	\$1,200
a) Payment to consulting physician	\$250	\$400
b) Technical charge	\$175	\$175
c) Residual payment for ensuring provider availability and education and support functions	\$425	\$625

The proposal and additional information provided by the submitter indicate that this bundled payment approach enables reductions in unnecessary transfer of patients to receiving “hub” facilities and more timely initiation of treatment for patients who can be appropriately cared for at the rural “spoke” facility. (The terms “distant” and “originating” sites, which are used by Medicare instead of “hub” and “spoke,” will be used for the remainder of this report.)

The ACCESS HCIA program experienced challenges enrolling hospitals, and as a result, the HCIA evaluator determined there were too few Medicare and Medicaid treatment beneficiaries to conduct a rigorous impact analysis. The HCIA evaluation reported anecdotal evidence from hospital and UNM staff that ACCESS patients received tissue plasminogen activator (tPA) more often and sooner because of the telehealth consultations. In cases of ischemic stroke where using tPA to dissolve blood clots is appropriate, guidelines recommend administration within three hours.¹ The use of clot-dissolving drugs such as tPA is time sensitive and carries a risk of excessive bleeding; thus, timely and accurate assessment for the appropriate administration and monitoring is very important. Cost modeling published by the submitter appears to use these data

¹ *Target: Stroke Campaign Manual: Time Lost Is Brain Lost*. American Heart Association/American Stroke Association; 2010. http://www.strokeassociation.org/idc/groups/heart-public/@wcm/@hcm/@gwtg/documents/downloadable/ucm_308277.pdf

on timely tPA administration in its estimate that ACCESS Telemedicine may save \$4,241 per patient in health care utilization costs in the 90 days post event.² Subsequent unpublished cost analyses from the submitter extend these results for ischemic stroke to the first year and lifetime after the event, estimating \$13,617 and \$35,761 in saving per patient, respectively.

2. Literature Review and Environmental Scan

ASPE, through its contractor, conducted a targeted environmental scan of peer-reviewed and non-peer-reviewed publications. The review included a formal search of: major medical and academic databases; relevant grey literature, such as research reports, white papers, conference proceedings, and government documents; and websites of professional associations/societies and Centers for Medicare & Medicaid Services (CMS) and CMMI for relevant evaluation reports and program documentation. The PRT sought additional information regarding neurological transfers from rural hospitals to urban tertiary care facilities and existing evidence of disparities in outcomes and quality of care for patients with cerebral emergencies in rural areas compared to other areas. ASPE, through its contractor, produced an additional supplemental literature review on these issues. Both documents are available on the ASPE PTAC [website](#).

3. Data Analyses

ASPE, through its contractor, used Medicare claims from 2015–2017 to produce data tables on: a) the frequency of selected neurological conditions presenting at rural hospitals; b) rates of transfer from rural hospitals to other acute care facilities; and c) discharge disposition. A neurologist provided clinical expertise to inform the selection of the neurological ICD-10 codes used in the analysis. The limited clinical information available on claims meant it was difficult to identify specific cases that would likely be eligible for the ACCESS Telemedicine program. The analyses are available on the ASPE PTAC [website](#).

4. Public Comments

There were no public comments for this proposal.

5. Other Information

ASPE communicated with staff in CMS, Center for Medicare (CM), and CMMI to gain a fuller understanding of the use of telemedicine fees to cover costs beyond the physician consult (e.g., technology platform costs). This information was used in developing questions for the submitter.

² Whetten J, van der Goes DN, Tran H, Moffett M, Semper C, Yonas H. Cost-effectiveness of Access to Critical Cerebral Emergency Support Services (ACCESS): a neuro-emergent telemedicine consultation program. *J Med Econ.* 2018;21(4):398-405. doi:10.1080/13696998.2018.1426591.

D. Evaluation of Proposal Against Criteria

Criterion 1. Scope (High Priority)

The proposal aims to either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM Entities whose opportunities to participate in APMs have been limited.

PRT Qualitative Rating: Meets Criterion and Deserves Priority Consideration

Strengths:

- The proposal aims to improve access to cerebral emergent care among Medicare beneficiaries in rural areas, where neurology workforce shortages challenge the ability for rural hospitals to care for such patients.
- The proposed model would strengthen the capacity of rural hospitals to provide cerebral emergent care through both the use of telemedicine consults with physician specialists at tertiary-care distal facilities and through rural originating site hospital staff training and education that increases rural providers' knowledge of and confidence in providing cerebral emergent care.
- The proposed model would allow rural hospitals to provide care to more neuro-emergent patients confirmed not to need transfer and be reimbursed for these services. This aspect contributes to the financial viability of rural facilities and allows patients to receive care in their own communities when appropriate.
- Notably, the model enables rural facilities to offer 24/7 coverage of cerebral emergent services, something that is currently substantially beyond the financial or technical capability of most rural hospitals.
- According to the submitter, the ACCESS Telemedicine program has had a positive effect on rural hospitals' recruitment and retention of physicians and staff.

Weaknesses:

- The criteria for determining whether a facility is eligible to participate in the model (e.g., health professional shortage areas, critical access hospitals, other) are not clearly defined. The submitter described a broad range of settings that may benefit from the ACCESS Telemedicine model and noted that the program could be beneficial in urban hospitals that lack 24/7 neurology and neurosurgery coverage. The submitter suggested eligibility criteria based on the physician services that are provided at a facility.

Summary of Rating:

The proposed PFPM meets the criterion and deserves priority consideration. The use of new technology to avoid inefficient duplication of services while expanding access despite constraints in the supply of neurological experts makes the scope of this proposal highly relevant.

Criterion 2. Quality and Cost (High Priority)

The proposal is anticipated to (1) improve health care quality at no additional cost, (2) maintain health care quality while decreasing cost, or (3) both improve health care quality and decrease cost.

PRT Qualitative Rating: Meets Criterion and Deserves Priority Consideration

Strengths:

- By giving rural providers access to neurological expertise for serving patients presenting with cerebral emergencies, ACCESS Telemedicine reduces the need to transfer some patients to facilities with neurologists for evaluation and treatment. Thus, ACCESS Telemedicine is able to prevent unnecessary and costly patient transfers to tertiary care facilities.
- The submitter provided data showing their model reduced transfers out of rural facilities from 90 percent before ACCESS Telemedicine implementation to 15 percent after ACCESS Telemedicine implementation. Reduced transfers not only lower expenditures on transportation services but also avoid burdening Medicare patients and families with unnecessary costs.

Weaknesses:

- Due to the limited amount of clinical information in Medicare claims data, analyses of Medicare claims, conducted by the ASPE contractor, were not able to substantiate the problems of unnecessary transfer or delayed treatment (e.g., for ischemic stroke patients) that are provided in the submitter's proposal. Failure to replicate the submitter's statistics (which include patients other than Medicare beneficiaries) does not invalidate their findings, since Medicare claims data do not allow identification of the specific patients who could benefit from ACCESS Telemedicine. However, it is difficult to assess the extent of the problem for Medicare beneficiaries or the potential for quality improvement and cost reductions.

Summary of Rating:

The proposed PFPM meets the criterion and deserves priority consideration. The ACCESS Telemedicine program is intended to improve quality of care for Medicare FFS beneficiaries who experience cerebral emergencies in rural areas. The program has a particular focus on reducing unnecessary transfers, which directly benefits both the patients as well as the viability of rural hospitals. By enabling 24/7 access to neurology and neurosurgical subspecialty expertise, rural hospital providers can be more confident in directly admitting patients they can care for appropriately.

Criterion 3. Payment Methodology (High Priority)

Pay APM Entities with a payment methodology to achieve the goals of the PFPM Criteria. Addresses in detail through this methodology how Medicare, and other payers if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the PFPM cannot be tested under current payment methodologies.

PRT Qualitative Rating: Meets Criterion

Strengths:

- The proposed ACCESS Telemedicine model offers a simple and clearly defined payment structure, with a single bundled amount for hospitals to bill. The amounts for the payments are based on documented methodology and/or program experience.
- The model seeks to mitigate existing telemedicine implementation challenges for rural facilities. Some teleneurology programs in the United States (not paid for directly by Medicare) charge a maintenance fee or annual subscription rather than a fee per use. The proposed model would remove the upfront investment required to purchase and maintain a telemedicine platform used for a low volume of services by charging per use, with no to minimal upfront costs to the rural facility.
- The submitter asserts that current Medicare reimbursement for telehealth is not adequate to cover costs and that the proposed bundled payment would make neurology telehealth consults financially viable to rural hospitals. The bundle covers telehealth consultation, staff education, data collection, and quality assurance.
- In addition to the telemedicine platform and access to remote consultations, the ACCESS Telemedicine program provides education and outreach to staff at rural facilities, which the submitter argues facilitates the use of telemedicine. According to the submitter, this continuing education and outreach is key to keeping rural providers engaged with and using the services in the face of low patient volume and high staff turnover in rural facilities.
- Viability of the model is supported by the fact that New Mexico's Medicaid program added the ACCESS Telemedicine program as a covered benefit effective 2019. The submitter is also working with Medicare Advantage plans and other managed care organizations to cover ACCESS Telemedicine.

Weaknesses:

- The proposed payment methodology departs from current Medicare payment policy in several ways:
 - Payments for consultation are different based on provider specialty (neurologist versus neurosurgeon).
 - Payments include costs of on-call availability.
 - The proposed payment structure would need to be reconciled with existing telemedicine payment through Medicare, as payment is sent to the originating site;

the originating site then makes the payment for the telemedicine platform services and passes along payment to the consulting provider at the distal site.

- While an underlying motivation of the payment model is to improve quality of care and reduce costs by reducing unnecessary transfers, the model as specified does not explicitly involve either upside or downside risk-sharing. However, the telemedicine consult, in the context of the full educational program of the ACCESS Telemedicine team, has the potential to save Medicare money, even as new forms of payment are created by the model. Some of the potential savings are shared by UNMHSC for new services rendered (e.g., staff education), and some of the savings flow to the remote hospital in terms of new admissions.

Summary of Rating:

The proposed PFPM meets the criterion, though some concerns remain. For example, the fair market value and other aspects of the payment methodology are specified but may not be sufficiently rigorous, so it is not possible to assess whether the calculated amounts are what would be appropriate for the Medicare program. Furthermore, Medicare payment historically does not directly support infrastructure costs such as the telemedicine platform. However, the proposed model using the telemedicine platform elicits beneficial coordination and technology that might not happen in the absence of such support. The program also focuses on education and administrative support in novel and creative ways, and such education/support may be a necessary condition for the telemedicine approach to work. In total, the PRT felt the model is sufficiently creative and has potential savings. Therefore, though risk-sharing is not explicitly included in the payment model, the payment models seem to be potentially highly cost-effective and possibly cost-saving. Further evaluation is needed to gain a better understanding of the exact payment parameters for the model and its long-run benefits and costs.

Criterion 4. Value over Volume

The proposal is anticipated to provide incentives to practitioners to deliver high-quality health care.

PRT Qualitative Rating: Meets Criterion and Deserves Priority Consideration

Strengths:

- The proposal seeks to reduce unnecessary transfers to tertiary care facilities and enable local providers to care for patients. Data provided by the submitter indicate that the ACCESS Telemedicine program resulted in fewer transfers and an increase in patients being discharged quickly following diagnosis and treatment in the ED.
- The submitter indicates that the education provided through the ACCESS Telemedicine program has resulted in greater comfort/confidence among rural hospitalists in providing care for neurology patients and therefore reducing transfers to tertiary facilities.

Weaknesses:

- Analyses of Medicare claims data were not able to identify claims representing patients who are good candidates for ACCESS Telemedicine and therefore could not replicate the problematically high current rate of transfers or failure to initiate timely treatment. Therefore, it is difficult to estimate the total implications for the Medicare program.

Summary of Rating:

The proposed PFPM meets the criterion and deserves priority consideration. As noted under the prior criteria, this program will enable providers to deliver high-quality health care, either in the originating site or by ensuring appropriateness of transfer for cases needing more advanced neurological care or neurosurgical resources.

Criterion 5. Flexibility

Provide the flexibility needed for practitioners to deliver high-quality health care.

PRT Qualitative Rating: Meets Criterion

Strengths:

- The proposed ACCESS Telemedicine model allows flexibility to provide care in rural settings rather than transferring cases out to distant facilities; these transfers might in some cases be unnecessary and in other cases might delay appropriate treatment.
- While the neurologist or neurosurgeon providing the telemedicine consult offers a recommendation, the originating rural physician retains the treatment decision-making. The originating rural physician can request a follow-up consult within 24 hours for no additional charge.
- The proposed model allows rural originating site facilities to retain their existing transfer relationships; it does not incentivize or expect transfers to go to the consulting physician's facility.
- The criteria for seeking a consultation under the model are flexible. Physicians can request a consult for any neurological condition, not just strokes, as is the case in many telestroke programs.
- The distant specialists providing telemedicine consults can be based anywhere rather than being limited to a particular hospital or health system, which may increase the pool of available physicians.

Weaknesses:

- Consulting neurologists and neurosurgeons will need to be licensed to practice in the state and credentialed by the facility where the patient is located. Requirements for licensure and credentialing vary across jurisdiction and may present a barrier to scaling the proposed model.

Summary of Rating:

The proposed PFPM meets the criterion. The PRT finds that the proposed program is highly flexible and adds treatment options without imposing any new constraints.

Criterion 6. Ability to Be Evaluated

Have evaluable goals for quality of care, cost, and any other goals of the PFPM.

PRT Qualitative Rating: Meets Criterion

Strengths:

- The submitter proposes quality measures and evaluation approaches in areas including patient experience, total cost of care, readmissions, transfer rates, and measures related to timeliness of care (e.g., imaging, tPA administration).
- The ACCESS Telemedicine quality assurance component includes collection and analysis of data on quality and timeliness of care. These data are reviewed for all stroke cases and one-third of other consultants.

Weaknesses:

- As with the original HCIA evaluation, the number of people who qualify for ACCESS Telemedicine at many facilities might be sufficiently limited such that rigorous evaluation may be difficult.

Summary of Rating:

The proposed PFPM meets the criterion. The PRT finds that provisions could be established for sufficient tracking and evaluation of outcomes.

Criterion 7. Integration and Care Coordination

Encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM.

PRT Qualitative Rating: Meets Criterion

Strengths:

- The proposed model attempts to improve coordination between different care settings, primarily rural hospitals and tertiary care facilities.

Weaknesses:

- The ACCESS Telemedicine proposal currently does not include EHR interoperability. The consulting specialist relies on the audiovisual patient examination, information provided by the rural physician, and imaging/lab results shared via cloud technology but does not

have direct access to information in the patient EHR that may inform diagnostic and/or treatment recommendations.

Summary of Rating:

The proposed PFPM meets the criterion. The PRT finds that an underlying goal of the program is to improve integration and care coordination.

Criterion 8. Patient Choice

Encourage greater attention to the health of the population served while also supporting the unique needs and preference of individual patients.

PRT Qualitative Rating: Meets Criterion

Strengths:

- By reducing avoidable transfers, the proposed model would allow more rural patients to receive care in their local community, which may align with patient and family preferences.
- Family member involvement is a strength of the approach since patient choice may be less relevant, given the potential cognitive impairment of a patient experiencing a cerebral emergency.
- As described by the submitter, the proposed model allows for patient and family member decision-making, to the extent the patient is able to participate. Before participating in a telemedicine consult, patients provide informed consent (or an appropriate health care proxy if the patient is not able to provide consent).

Weaknesses:

- None noted.

Summary of Rating:

The proposed PFPM meets the criterion. ACCESS Telemedicine is intended to support the needs and preferences of individual patients within a framework based upon access to high-quality expertise.

Criterion 9. Patient Safety

How well does the proposal aim to maintain or improve standards of patient safety?

PRT Qualitative Rating: Meets Criterion

Strengths:

- The proposal acknowledges recognized standards for patient safety that will be followed and also emphasizes the importance of evidence-based care.

- The model aims to strengthen rural providers' capacity to provide care for patients with neuro-emergent conditions through learning from the specialists providing consults as well as through the training, education, and clinical support provided through the ACCESS Telemedicine program.

Weaknesses:

- None noted.

Summary of Rating:

The proposed PFPM meets the criterion. The program specifications address relevant components of patient safety.

Criterion 10. Health Information Technology

Encourage use of health information technology to inform care.

PRT Qualitative Rating: Meets Criterion

Strengths:

- The proposal relies on telemedicine technology to provide cerebral emergent care in settings that lack adequate neurologist or neurosurgeon access. This use of technology allows for remote specialist consultations and sharing of test results (e.g., imaging), giving rural and isolated providers access to expertise not available in their communities.

Weaknesses:

- The submitter currently relies on a third-party company, NMXS, for the telemedicine platform and connection to remote physician specialists. However, the submitter states that this arrangement is flexible, and other companies could provide similar services should the model be expanded.
- Interoperability of HIT across different institutions and with telemedicine platform vendors outside of NMXS could be challenging.

Summary of Rating:

The proposed PFPM meets the criterion. The proposed model would enhance exchange and storage of information via a technology platform.

E. PRT Comments

The PRT believes that the ACCESS Telemedicine model takes a big step toward addressing the real problem of access to specialist care for cerebral emergencies in rural areas. The proposed model would allow for a transition from duplication of resources and unnecessary transfers under the current health care system to a system that uses new technology to provide right-sized care. The program makes innovative use of technology while considering capabilities of rural facilities, thereby improving access to high-quality care in rural areas.

Further, ACCESS Telemedicine has the potential to improve quality and outcomes for patients while saving costs to Medicare and to patients/families by reducing unnecessary transfers. The program also: 1) can reduce the burden on patients to travel long distances for care when care in the local area is sufficient, and 2) may contribute to the financial viability of rural facilities by enabling them to keep more patients (and the revenue associated with those patients) in house.

The PRT notes several aspects of the payment model that are unconventional but may also be innovative in improving care. The payment model extends beyond what Medicare traditionally pays for, with special emphasis on education/training, technology, and quality assurance costs. The approach involves a marked change from how Medicare pays for telemedicine services at present (in particular, paying the originating site and requiring them to pass along payment to the consulting provider at the distant site and covering telemedicine platform costs). Implementers will need to address licensure and credentialing that, due to legal requirements, will need to be handled state by state (licensing) and facility by facility (credentialing), though the submitter recognizes the importance of these issues and arrangements.

While some aspects of the payment model undoubtedly should be considered further, especially through evaluation, the model may be a harbinger of new roles for academic medical centers (AMCs). Historically, teaching hospitals often provided services that could not be delivered or developed in community hospitals. Recently, a JAMA Viewpoint author raised the question of whether some AMCs may have grown too large to survive a changing health care system, much less be leaders in innovative change.³ The ACCESS Telemedicine proposal provides an example of innovation in care delivery for which AMCs may be uniquely positioned, specifically enabling rural hospitals to enhance access to quality care at different levels for patients as needed.

³ Johnston, SC. Academic medical centers: Too large for their own health? *JAMA*. 2019;322(3):203-204. doi:10.1001/jama.2019.6834

APPENDIX 1. COMMITTEE MEMBERS AND TERMS

Jeffrey Bailet, MD, Chair

Grace Terrell, MD, Vice Chair

Term Expires October 2019

Paul N. Casale, MD, MPH
New York Quality Care
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University College of Physicians and
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Rhonda M. Medows, MD
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Term Expires October 2021

Jeffrey Bailet, MD
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Angelo Sinopoli, MD
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Kavita Patel, MD, MSHS
Johns Hopkins Health System
Baltimore, MD

Jennifer Wiler, MD, MBA
University of Colorado School of Medicine
Aurora, CO

ⁱ Section 50325 of the Bipartisan Budget Act of 2018 amended section 1834(m) of the Act by adding a new paragraph (6) that provides special rules for telehealth services furnished on or after January 1, 2019, for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke (acute stroke telehealth services), as determined by the Secretary. Specifically, section 1834(m)(6)(A) of the Act removes the restrictions on the geographic locations and the types of originating sites where acute stroke telehealth services can be furnished. Section 1834(m)(6)(B) of the Act specifies that acute stroke telehealth services can be furnished in any hospital, critical access hospital, mobile stroke units (as defined by the Secretary), or any other site determined appropriate by the Secretary, in addition to the current eligible telehealth originating sites. Section 1834(m)(6)(C) of the Act limits payment of an originating site facility fee to acute stroke telehealth services furnished in sites that meet the usual telehealth restrictions under section 1834(m)(4)(C) of the Act.