**Informing PTAC's Review of Telehealth and PFPMs: We Want to Hear from You Responses**

On September 18, 2020, the Physician-Focused Payment Model Technical Advisory Committee (PTAC) requested input from the public on information that could help inform their review of the use of telehealth to optimize health care delivery under physician-focused payment models (PFPMs) and alternative payment models (APMs). PTAC received nine responses from the following stakeholders that are listed below in the order in which their responses were received:

1. Eitan Sobel, MD
2. Center for Healthcare Quality & Payment Reform
3. American Physical Therapy Association
4. American Academy of Family Physicians
5. National Committee for Quality Assurance
6. National Association of Pediatric Nurse Practitioners
7. OCHIN
8. Jean Antonucci, MD
9. Partnership to Empower Physician-Led Care

For additional information about PTAC's request, see PTAC's solicitation of public input.

**9/24/2020**

**Physician-Focused Payment Model Technical Advisory Committee (PTAC)**
**c/o US DHHS Asst. Secretary of Planning and Evaluation Office of Health Policy**
**200 Independence Ave.,**
**SW. Washington DC 2O20I**

**TITLE: THE 'MONEY-PIT' BUSINESS OF REMOTE CARE (TELEHEALTH).**

**Are there experiences and lessons learned?:** Not long ago, we were inspired by the emergence of EMR technologies. The promise of better care, cost-saving, error reduction, and better communication prompted us to heavily invest in those technologies.
EMR technologies indeed improved care delivery but the results were nowhere close to what we hoped to achieve. Many small entities like private physicians and small clinics did not survive the technology revolution and had to close. The cost of healthcare skyrocketed beyond imagination. We have successfully created monopolies in this game and therefore, very little improvement and development of the technologies was made over the past 15 years. We accepted the monopolies as inevitable, and we generously paid them with public money. We failed to push back.

**The opportunity:** Remote Care is an opportunity to learn from our past experience. We need technologies that are much more than just "Zoom" applications associated with EMRs. The technologies should enable providers to manage larger groups of patients and to respond to multiple communications and needs. The current EMRs imitate the old 'medical record' of physicians. It is merely 'horizontal thinking' while new technologies are needed to support 'vertical thinking'. The remote care technologies may initially work in conjunction with EMRs and eventually should replace them in order to prevent duplications. We should be able to control the development of new technologies and not be controlled by them.

**How might telehealth help to optimize care within and across services?** Remote care can and should be used anywhere within and across services. Remote care could be particularly effective between a lower level of care and a higher level of care but could be used at the same level of care as well. Remote care prevents duplication of care. For example, a visiting nurse in the field raises some concerns about a patient. Remote care offers immediate contact between

the nurse and a primary care provider or a standby provider. There is no need to wait a week for an appointment with the primary provider during which the condition of the patient could get worse. There is also a good chance that the issue could be resolved via remote care and then there is no need for an urgent appointment. Perhaps the most useful situation is the interaction between a provider and a specialist. For example, providers operating at a lower level facility such as hospitalists can get specialists at higher-level facilities involved directly in the care of their patients without transferring the patients. Remote care could be used within an organization or a facility to simplify care and to save time and money.

**Productivity:** Remote care can increase our productivity. As described above, with appropriate technology, a supportive and reliable team, we can increase our productivity and provide low-cost care for larger populations.

**Teamwork:** Remote care technology is about interaction and direct continuous communication among members of the care team and patients. Teamwork is about relying on each other and trusting the work and conclusions of other members of the team.

**Better care:** Remote care does not replace direct patient contact but it adds another dimension of care. Remote care will improve care, prevent unneeded escalation of care, or alternatively bypass unnecessary steps of escalation that are unneeded, costly, and sometimes damaging.

**Cost Reduction**: Remote care could easily become yet another 'money pit' with multiple parallel care systems that do not support each other and practically doubling our cost of healthcare. The PTAC should be particularly concerned about endorsing specific remote care programs that seemingly save money and improve care. Expanding those programs may produce the opposite effect. Furthermore, approving only certain specific programs may exclude other remote care applications that could potentially save substantial costs. Cost reduction should be figured as savings for the system as a whole, and therefore, the system should be evaluated as a whole. Our objectives should be not just halting spending but actually reducing costs. Carefully detailed design of remote care today would substantially cut our healthcare costs tomorrow.

In my proposals from 2019 and 2020: **Remote specialists and experts on-demand - improving care and saving costs**, I explained how early involvement of specialists could be implemented. Local services and traditional providers' appointments are too slow and costly.

The availability of remote care is immediate and does not depend on the workload of local specialists. Remote care offers scalability of services and flexibility that cannot be achieved by local programs. In addition, remote care promotes early involvement of other expert services such as social services, palliative care, wound care, and many other expert services that will reduce costs, prevent escalation, and improve care.

**Competition:** Our current system promotes monopolies. It is designed to avoid oversaturation of the market. The result is monopolies of providers, clinics, and hospitals. Even our technology companies enjoy an uncontested market. Remote care will open the system to competition which will improve care and reduce cost.

**Continuation of care:** Our healthcare system demolished parts of the old patient-doctor relationship. The principle of continuation of care was partially lost. The patients are exposed to multiple teams of care that have to learn everything about the patient again and again relying on a transition of care documentation that is not always flawless. The process diminishes trust in the system, exhausts patients and providers, and adds significant costs. Remote care should be built on the continuation of care principles that will improve care, increase trust, and save costs.

**What might be the most informative performance-related metrics and strategic approaches for monitoring and evaluating the use of telehealth as part of care delivery?**
The PTAC should be leery about performance-related metrics and benchmarks, as those are likely to drive the cost up. In addition, metrics do not necessarily translate into better care as providers are pressured to provide services and treatments aiming to satisfy requirements and benchmarks rather than to benefit patients. Remote care should be evaluated by patient satisfaction and efficiency of care and therefore, I am suggesting creating regional referral centers (RRC).

**Patient choice:** Choices and market-driven economy are a great strategy for monitoring and evaluating the use of remote care. Patient choice is linked to competition and competition improves the quality of care. Remote care technologies will provide Amazon-like portals that will present patients with alternative choices and will allow them to provide feedback and recommendations.

**Regional referral centers (RRC):** In my proposal, I offered to create virtual organizations called regional referral centers that will oversee and manage the interaction among the members of the health care team including specialists and experts, and the patients. The referral centers are responsible for the coordination of care, efficiency, and potentially will be given the power to negotiate contracts with providers and organizations. The regional referral centers will be held accountable for outcome and cost. Poorly managed RRCs could easily be replaced.

**The building blocks:** We have all the building blocks needed to create a great healthcare system. We have the providers, the facilities, the technologies, and the networks necessary for creating a better future of affordable healthcare in America. We just need to put it together.

**I applaud the PTAC's attempt to gather public comments and thoughts about remote care. This document is probably the tip of the iceberg and the devil is in the details. Remote care is a whole new dimension of medicine that requires careful planning to get it right, as we cannot afford to get it wrong.**

<u>**Reference:**</u>
**PTAC proposal: Eitan Sobel:**
Remote specialists and experts on-demand - improving care and saving costs.

Respectfully,

Eitan Sobel, MD
Hospitalist.
(802) 345-4378

CENTER FOR
HEALTHCARE
QUALITY &
PAYMENT REFORM

320 Ft. Duquesne Boulevard
Suite 20-J
Pittsburgh, PA 15222
Voice: (412) 803-3650
Fax: (412) 803-3651
www.chqpr.org

September 30, 2020

Jeffrey Bailet, Chair
Physician-Focused Payment Model Technical Advisory Committee
c/o Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
Room 415F
200 Independence Avenue SW
Washington, DC 20201

RE: Request for Public Input on PTAC's Review of Telehealth and PFPMs

Dear Dr. Bailet:

It is quite clear that in a large number of circumstances, telehealth is a highly beneficial service for patients, and in many circumstances, it is an essential service. It is also quite clear that telehealth services cannot be delivered if they are not paid for, and until the spring of 2020, most of them were not paid for.

The challenge now is whether and how to continue those services. Medicare is currently paying separate fees for those services in addition to all of the other thousands of fees it pays for office-based services. That's a *payer-centered* approach, not a *patient-centered* approach.

The patient-centered approach is to pay physicians to diagnose or treat patients' health problems in a way that gives physicians the flexibility to use whatever approach or location will have the best outcome at the lowest overall cost.

A number of physicians and provider organizations have designed payment models that would do just that – provide flexible patient-centered payments tied to health problems, services, or outcomes, not to specific places. PTAC has recommended a dozen of these models over the past three years. In fact, the very first model PTAC recommended in 2017 was Project Sonar, which was designed to enable physicians to monitor patient symptoms remotely.

Unfortunately, CMS has not implemented a single one of these models. If CMS had implemented them, thousands of patients could have been benefiting from telehealth services long before the pandemic.

CMS has said that it would take years to implement PTAC's recommendations and it doesn't have the bandwidth to do that. Miraculously, though, CMS found the bandwidth in 2020 to issue over a hundred pages of regulations making 50 separate changes to Medicare payment rules, more than two dozen of which were related to telehealth.

It certainly didn't take physicians years to implement the changes. Almost overnight, the use of telehealth services skyrocketed. It was clear that the payment system was the barrier, not physician or patient resistance.

It shouldn't require a pandemic in order to get the changes in payments that will help patients get better care. Congress clearly needs to change the law so CMS is required to implement more physician-focused payment models more quickly.

Sincerely,

Harold D. Miller
President and CEO

October 8, 2020

Stella Mandl, RN, BSN, BSW
PTAC Staff Director
Office of Health Policy
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

*Submitted electronically:* PTAC@HHS.gov

**RE: Request for Public Input on PTAC's review of telehealth and PFPMs**

Dear Ms. Mandl:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association appreciates the opportunity to submit comments in response to ASPE's Request for Public Input on the Physician-Focused Payment Model Technical Advisory Committee's review of telehealth and physician-focused payment models. APTA is dedicated to building a community that advances the physical therapy profession to improve the health of society. As experts in rehabilitation, prehabilitation, and habilitation, physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability for individuals across the age span, helping improve overall health and prevent the need for avoidable health care services. Physical therapists' roles include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession's vision of transforming society by optimizing movement to improve the human experience.

APTA provides the following comments to ASPE's questions to the public, below.

**2. Are there changes related to the use of telehealth technology, such as changes in scheduling, care delivery workflow, staffing, quality standards, information and supports needed by beneficiaries, etc., that may be required to optimize its use?**

During the COVID-19 pandemic, society has learned that telehealth brings value to the health care landscape, although rapid adoption brought challenges. Patients want access to telehealth on their own terms, from the comfort of their homes. To promote greater access to telehealth, patients need access to broadband and technologies that can support the delivery of telehealth. Further, maintaining continuity of care for patients to the extent possible is critical. This helps avoid negative and unintended consequences from delayed preventive, chronic, or routine care. Please see our comments below.

**3. Within the APM context, how can stakeholders leverage telehealth to enable coordinated and integrated care delivery for Medicare beneficiaries who need frequent or complex services across a variety of providers? For example, how might telehealth help to optimize care for these patients within and across services and settings such as: Primary care; Outpatient specialty care; Urgent care; Emergency services and observation settings; Acute care, including substitutes to traditional inpatient care, such as hospitals at home; Other home health care models; Long-term care; Post-acute care; Dialysis services; Mental health services; and Other.**

Opportunities exist for greater levels of patient safety in telehealth. In a post-COVID-19 world, we may become more sensitive to exposing ourselves to someone with a cold or another known or undiagnosed

illness. Telehealth can ensure that continuity of care is maintained without having to force sick people — or those for whom getting sick from others could be a serious health issue — out into the community.

Whether in an APM or not, telehealth allows a physical therapist to co-treat with another clinician who is treating via real-time audio and visual technology. It also allows a treating physical therapist to consult directly with another physical therapist or a physical therapist assistant for collaboration, and/or to obtain specialty recommendations to incorporate into an existing plan of care.

As APTA communicated to PTAC in October 2017 in response to Avera's intensive care management in skilled nursing facility APM, and in subsequently offered public comments, incorporating telehealth is often a key to success, as it allows providers to serve beneficiaries in many communities while enhancing the patient experience and improving the efficiency of care delivery. However, APMs must ensure they include all relevant stakeholders, including physical therapists. Telehealth improves access to physical therapy for patients who have mobility issues, especially during COVID-19 and continuing in its aftermath. Telehealth also is an effective way to get physical therapists into communities that otherwise would lack access to their services, and to enable them to provide triage care and manage upstream and downstream costs and care.

**4. In what areas is further evidence about telehealth needed?**

While there are a growing number of studies that demonstrate the clinical efficacy of telehealth services furnished by physical therapists (see Appendix A), APTA would be interested in further evidence of physical therapy telehealth adoption data across all settings — particularly in acute care hospital systems and post-acute long-term care facilities.

Furthermore, to fully determine the effect of telehealth on prevention, urgent care, post-acute care, etc., the full scope of services provided via telehealth and meaningful outcomes of care must be captured, as well as accounting of upstream and downstream spending. Also, the ability is needed to compare outcomes for patients who receive all care via telehealth, all care in-person, or via a combination — with some means to risk-adjust populations in and across groups. It is critical that further research be done to assess telehealth use among providers traditionally overlooked in the telehealth arena, including physical therapists and post-acute care providers.

In order to facilitate this evidence base, future APM- and PTAC-submitted telehealth proposals should include interprofessional and rehabilitation components of the award criteria in order to investigate meaningful outcomes and benefits to Medicare beneficiaries.

**5. In the context of APMs for Medicare beneficiaries, what might be the most informative performance-related metrics and strategic approaches for monitoring and evaluating the use of telehealth as part of care delivery?**

APTA suggests the following:

- Functional status, regardless of diagnosis.
- Claims data: visits/services.
- Ratio of in-person to telehealth visits.
- Use of telehealth by enrollee ZIP code.
- Care duration.
- Assessment of most efficacious timing of telehealth intervention (i.e., during start, middle, or end of episode of care).
- Outcomes data/result of standardized measures.
- Total cost and services across all disciplines and settings for the same episode of care.
- New conditions and complications arising during care.
- Patient-reported outcomes and satisfaction.

- Transfers to other providers and reason for these transfers.
- Admissions to the emergency department.
- Readmissions to the hospital and post-acute care facilities.
- Comparison of outcomes within specific groups (diagnostic, geographic, age ranges, socioeconomic) based on the inclusion of telehealth in the episode or no telehealth during the episode.
- Identification of technology used and challenges for beneficiaries.
- Social risk factors and determinants of health limiting access to telehealth services.

CMS also should furnish providers with data at the six-month and one-year post-episode discharge limits — including exacerbations and recidivism, medical and pharmaceutical usage post-discharge, hospital readmissions, and adverse events. Having access to those types of data would help physical therapists assess patients' functional status and the value of physical therapist interventions, better understand the impact of the physical therapist on total cost of care, inform iterative clinical care improvements, identify dose specifics and reduce unwarranted variation in care, and recognize best practice and centers of excellence for specific conditions.

This data also would help educate treating providers and collaborative partners on best practice and benefit design, as well as identify opportunities and elucidate areas for increased or changed collaboration with other disciplines. Additionally, this data would facilitate comparison of the value of interventions by different providers to determine under what circumstances an intervention works best for a particular condition. For example, this could help payers and patients better understand the impact of conservative care on medication usage — specifically regarding the use of opioids to manage pain. Moreover, this would help support the shift away from traditional utilization management while also reducing administrative burden.

   a. **Given potential disruptions in claims data due to the COVID-19 Public Health Emergency (PHE), what are the best approaches to constructing benchmarks or comparison groups for payment and evaluation purposes?**

Assessing the impact of telehealth during the COVID-19 pandemic should consider for the fact that telehealth was rapidly expanded. Many providers were forced into telehealth without the opportunity to establish an optimal system and environment for delivery. The multiple waivers and the urgency to address delays and interruptions in care create an opportunity to learn, but not to assess true impact. Three points of comparison ultimately must be examined: 1) the pre-COVID telehealth environment, 2) the telehealth environment during the PHE, and 3) the post-PHE telehealth environment.

The PHE telehealth environment should be considered an opportunity for quality improvement. It also is important to evaluate the impact of delays and interruptions in care, and to compare populations who were able to access telehealth services with those who were unable to do so. Further, the impact should be evaluated in the context of specific care.

In addition, an analysis is needed of episodic cost of care prior to versus post-expansion and analysis of patient satisfaction.

It also will be important to look at data to better understand which delays and interruptions in care resulted in negative outcomes. Consideration must be given to meaningful patient clinical outcomes. From a physical therapist's perspective, it is important to compare a patient's functional performance, pain level, and quality of life at several points — start of care, point of interruption in care, point of resumption of care — against what services that individual received. It also will be important to review data regarding delays in care for the payers/entities that delayed telehealth implementation.

   b. **What might be the ideal measures and/or measure sets that would adequately detect provider performance and high quality outcomes? What measures/measure sets could**

**inform performance and enable program monitoring on care delivery issues such as access, costs, stinting, etc.?**

Criteria should include patient report and patient satisfaction, access to care, episodic cost of care, clinical outcomes and appropriateness, patient preference, and ease of treatment. There have been many studies illustrating the clinical benefit of telerehabilitation for a variety of conditions, including pelvic floor dysfunction and multiple sclerosis. A 2019 study examined the efficacy of home-based telerehabilitation versus in-clinic therapy for adults after stroke, finding that poststroke activity-based training resulted in substantial gains in patients' arm motor function, whether provided via telerehabilitation or in person.

To ensure that beneficiaries continue to receive high-quality care and to avoid stinting on medically necessary services, APTA also suggests the following:

- Assess provider adherence to clinical practice guidelines.
- Require completion of patient-reported satisfaction surveys at discharge.
- Require collection of standardized patient-reported outcome measures that have clinical utility and importance in improving care delivery. Such measures should be meaningful to a diverse set of providers and across disciplines. For example, CMS could require physical therapists within the model to use the Patient-Reported Outcomes Measurement Information Systems, or PROMIS.
- Require the use of specific performance-based (observation-based) outcome measures, such as Timed Up and Go and Gait Speed.

Other ideas:

- Have providers and CMS collect patient-reported outcomes and patient satisfaction surveys at the end of care. Establish a patient follow-up mechanism for complaints and compliments, with a tracking and trending system to monitor resolution and changes enacted to address deficiencies.
- Have CMS track hospital readmission rates, transfers to other providers, adverse events, medical services, and pharmaceutical usage post-discharge.
- Consider follow-up data collection at six months to a year post-discharge, as this would give CMS another data point to assess long-term benefit and adherence. This could be accomplished by including the physical therapist annual checkup as part of the benefit under the model.

It also is important for payers to support the development and success of professional registries as we move toward outcomes-based payment and advanced quality-reporting structures that will rely heavily on electronic data submission. Development of these registries has been spurred by the need to create meaningful quality measures to assist providers in the shift to value-based payment and models of care. These registries will be critical to the success of innovative payment models in the future, as they can deliver real-time data to providers for monitoring, assessing, and responding to new and dynamic models of care delivery.

CMS could use registries and other mechanisms to track providers participating in Medicare and Medicaid APMs that furnish telehealth, and take measured action based on the data. However, providers should first be able to remediate and use the data iteratively to improve practice patterns and patient communications. Additionally, quarterly performance reports that include benchmarks (once available) will reinforce and facilitate behavior change and practice improvements.

Qualified Clinical Data Registries, such as APTA's Physical Therapy Outcomes Registry, capture relevant data from electronic health records and billing information. They transform this data into meaningful, intuitive, and actionable feedback for providers on the frontline of patient care. Models of care that incorporate telehealth require physical therapists to have access to real-time data so that they can successfully identify and modify care design to maximize patient outcomes. The use of real-time data also allows for better coordination throughout the continuum of care and can be used to break down traditional

silos. However, greater financial support to small and rural providers is critical in order to facilitate their involvement in their profession's registry.

**6. Are there any measures that are specific to program integrity that are important to consider as it relates to encouraging use of telehealth after the PHE? How, if at all, would these measures be different under FFS or APMs?**

Whether used in fee-for-service or APMs, telehealth can be both another kind of care and a different care modality. It is important to identify telehealth as both. Telehealth/virtual care technologies can be used to enhance program integrity because telehealth services are easier to validate and verify. There will be a log from the telecommunications company indicating that the call or video was conducted, and its duration. This can be used to verify that services are being delivered and align with documentation in the medical record.

APTA has developed numerous resources to help ensure that the physical therapy profession has the necessary information to be successful in delivering services via telehealth, including the numerous considerations and precautions that must be taken when implementing a telehealth program to ensure eligibility and compliance with federal, state, and local laws, and with professional obligations.

**7. What educational information would you suggest that payers and providers can provide to Medicare beneficiaries and their caregivers to maximize the use of telehealth?**

Payers should be required to provide beneficiaries with information regarding how utilization of telehealth impacts their benefits, and if there is a limitation on use of telehealth. To that end, we suggest that payers provide separate benefit limits.

Additional information that payers should provide to beneficiaries includes: patient and provider eligibility to access telehealth, and any limitations; cost sharing (whether telehealth services have the same or similar cost sharing as do services furnished in-person); patient satisfaction with telehealth, allowing beneficiaries to compare satisfaction across providers; and technology needed to engage in telehealth services that are covered by the plan.

Both payers and providers also should be required to educate beneficiaries that telehealth is an option but is not required, and that they still can choose to receive services in-person. They must also educate beneficiaries on whether telehealth is or is not an option based on their condition(s). They must provide education to beneficiaries and their caregivers on how to set up and use telehealth, and they must be available to answer any questions. To the greatest extent possible, payers and providers should stipulate which procedures they do and do not cover/provide via telehealth.

Providers should also inform beneficiaries of telehealth technology as required by informed consent laws. Further, providers should educate beneficiaries on how providers and vendors of the technology are protecting patient-protected health information. Last, providers should share with patients any clinical studies on the efficacy of telehealth that are relevant to their conditions. Payers should reimburse providers for any additional educational time required outside of delivery of services.

Educational information should focus on primary care and first triage Medicare beneficiaries to telehealth services including physical therapy in order to minimize upstream and downstream costs. For example, educational material should emphasize that the standard of care is a primary care referral for a physical therapy telehealth visit prior to imaging or opioid utilization for low back pain management. The University of North Carolina's care delivery model for new onset of lower back pain, as shown in ASPE's *Environmental Scan on Telehealth in Context of Alternative Payment Models (APMs) and Physician-Focused Payment Models (PFPMs)* from September 9, 2020, emphasized patient education and decision-making tools, and nurse navigators. Triage to physical therapy in-person and telehealth options can be readily available; additional examples include simulation training for VA primary care providers

and triage to physical therapy non-opioid management. Last, Medicare beneficiaries should be educated on potential online abuse and fraud, including but not limited to lack of patient provider relationship to prescribe durable medical equipment and other ancillary services.

**8. How might barriers related to the use of proprietary telehealth platforms, software, and tools be overcome to enable their use in care delivery models and APMs for Medicare beneficiaries?**

We recommend the following to overcome barriers related to the use of proprietary telehealth platforms, software, and tools:

- A standardized data-collection format to ease further integration with EHR software.
- Standardized naming of telehealth tasks.
    - When different proprietary systems have different names for functions, providers and patients need to take extra time to learn a new platform upon switching to it.
        - For example, if platforms differ on what to label the function that enlarges or shrinks the picture (e.g., "enlarge/shrink," "zoom in/zoom out," "bigger/smaller"), beneficiaries with intellectual disabilities may find this problematic.
- A requirement that every product used for telehealth be HIPAA-compliant.
    - HHS should maintain a list of all HIPAA-compliant products, and each platform should receive HIPAA-compliant certification from HHS. The agency should remove any products that it finds are no longer compliant with HIPAA. CMS should deny reimbursement for services provided with any noncompliant products. HHS should also make sure that partners of the providers are HIPAA compliant and have valid business associate agreements.
- Proprietary systems should be prepared to be interoperable with all systems and not just a single EMR.

Additionally, as noted in ASPE's September 2020 report, payers should shoulder the investment associated with identifying the best technologies to use and expand the evidence base, with innovation at the provider level. Such payer investment would address barriers to proprietary platforms, software, and tools, with key applications that apply across a variety of care settings, specialties, and patients. One example is to incentivize current interfaces between EHRs and use of telehealth platforms within EHR portals for care-delivery models and payment. Also, direct-to-consumer telemedicine portals should abide by built-in metrics for APMs and bundled payment models. Stand-alone practices may require payment flexibility to participate in APMs and care delivery models for Medicare beneficiaries. They should use recommended platforms, software, and tools commonly used in the community at the provider level to encourage innovation. In addition, future tools may require modifications to address disability and key metrics; language translation with medical interpreters and availability of closed captions in various languages can become core features to access services.

**9. Ensuring high quality care and access to services is critical for successful health care delivery. What are major telehealth barriers for Medicare beneficiaries related to equity such as access to broadband, technology, or familiarity with the technology, and how might they be addressed? What policies, best practices and technical approaches have providers and other stakeholders used to help mitigate these barriers?**

To facilitate telehealth expansion, APTA supports policy proposals to fund high-quality broadband access for patients and providers — including physical therapists and other rehabilitation professionals, who often are not eligible to receive grant funding from the Federal Communications Commission. Federal programs also should promote greater funding and support to patients with limited technology and connectivity, and offer flexibility in platforms that can be used for audio and visual (live video) interactions, audio-only options, online patient portals, etc. Beneficiaries should not be asked to pay for anything other than their own residential broadband connection. Providers should be able to receive the highest-

bandwidth internet connection, but should consider having a different backup source for internet access. For example, if the main connection is fiber optic, providers might have cable or DSL as a backup.

Lack of interoperability between providers is a barrier to an integrated quality measurement system and data sharing. Physical therapists were excluded from the Meaningful Use program and have not received any financial or technical assistance to adopt and implement certified electronic health record technology. APTA's goal is to help the industry, through our advocacy efforts, adopt more certified electronic health record products for our physical therapy providers. The ONC certification process has established standards and other criteria for structured data that EHRs must use, but several of the criteria are not applicable to physical therapists and other nonphysician professionals. Accordingly, vendors that develop and offer EHRs for physical therapists and other rehabilitation providers are not attempting to certify their products due to their understanding that their EHRs do not encompass the necessary components to satisfy the certification criteria. This results in physical therapists not having EHRs that are interoperable with those used by hospital systems and physicians. APTA continues to urge CMS and ONC to assist physical therapy providers in obtaining CEHRT.

Further, to ensure that providers are able to furnish telehealth and that patients are eligible to receive services through such platforms, pay for telehealth versus in-person care should adopt a concept of parity that includes equal coverage, reimbursement, and cost-sharing (copayments, co-insurance, and deductibles) for audio-only telehealth, audio and visual telehealth, and in-person visits—especially given the fact that telehealth is merely a modality to enable physical therapists and physical therapist assistants to provide care within their scope of practice. For some services, however, payment for telehealth will vary from payment for in-person care due to the practice expense and liability portion of the code value. For example, aquatic therapy is an exception to telehealth because part of the practice expense portion of the code for it accounts for the pool. The mode of telehealth should be less of an issue moving forward, as telephone or patient portal-only services can be represented by utilization of the appropriate CPT code.

In terms of best practice, physical therapy phone-based triage of osteoarthritis treatment and management is safe and moderately effective in trials. Therefore, adding audio-only telehealth services to address lack of broadband, lack of provider access, and lack of acceptance to interactive audio and video may be a workable solution for some providers during and after the pandemic.

**10. In the context of APMs for Medicare beneficiaries, what federal and/or state policy issues exist that may need to be addressed for appropriate and effective telehealth use, such as Health Insurance Portability and Accountability Act privacy and security rules?**

To protect patient privacy while ensuring interoperable telehealth access, APTA suggests that providers be required to use HIPAA-compliant platforms and, to ensure patient privacy, develop standard policies and procedures to follow when providing telehealth. Federal and state governments also should develop telehealth-specific patient privacy controls.

Currently, Medicare beneficiaries are statutorily limited from receiving telehealth services related to geography, site, and provider. Congress must pass legislation that permanently affords providers and patients the ability to furnish and receive telehealth, just as they have done during the COVID-19 PHE. This includes waiving the restriction on geography and location, allowing the patient to receive telehealth in his or her home (whether in a rural or urban location), and expanding the ability of physical therapists, physical therapist assistants, and facility-based therapy providers to provide telehealth under Medicare.

Federal and state policies also should provide greater clarity on which states require informed consent and how it must be obtained, payers' documentation requirements, policies and procedures, etc. Further, federal and state governments should be consistent when developing policies to help reduce administrative and financial burden on both providers and patients.

Additional issues that must be addressed include licensure laws and requirements, and state practice acts. For example, providers may be willing to treat patients across state lines via telehealth but may face uncertainties regarding licensure or insurance requirements. The federal government can encourage states to implement compacts, such as the Physical Therapy Compact, to ensure the maximum number of providers are available to their residents. (CMS clarified in May 2020 that it recognizes interstate license compacts as valid and full licenses for purposes of meeting federal license requirements).

**Conclusion**

APTA appreciates the opportunity to comment on PTAC's review of telehealth and PFPMs. Should you have any questions, please contact Kara Gainer, director of regulatory affairs, at karagainer@apta.org or 703-706-8547, or Steve Postal, senior specialist of regulatory affairs, at stevepostal@apta.org or 703-706-3391. Thank you for your consideration.

Sincerely,

Sharon L. Dunn, PT, PhD
Board-Certified Clinical Specialist in Orthopaedic Physical Therapy
President

**Appendix A**

The following studies demonstrate how telehealth is leveraged in physical therapy to promote cost savings, improved outcomes, increased access, and higher patient satisfaction:

- A report published on August 14, 2020, in the American Journal of Physical Medicine and Rehabilitation described feasibility of and satisfaction with telerehabilitation based on the completion of online surveys by 205 participants following a telerehabilitation visit. Findings included:
    - Most commonly, participants were women (53.7%), were 35-64 years old, and completed physical therapy (53.7%) for established visits of 30-44 minutes in duration for primary impairments in sports, lower limb injuries, and pediatric neurology.
    - Overall high ratings ("excellent" or "very good" responses) were observed for all patient-centered outcome metrics (ranging 93.7%-99%) and value in future telehealth visit (86.8%) across telerehabilitation visits.
    - Women participated more frequently and assigned higher ratings than did male participants.
    - Other benefits of telehealth included eliminating travel time, incorporating other health care advocates, and conveniently delivering care to pediatric patients in a familiar environment.
    - Technology and elements of hands-on aspects of care were observed limitations.

- The Role of Virtual Rehabilitation in Total and Unicompartmental Knee Arthroplasty [*J Knee Surg*. 2019 Jan;32(1):105-110.]

    - Conclusion: Virtual rehabilitation is effective for certain patients and enables on-demand rehabilitation, offers cost savings, allows for coordination of care, and may improve adherence and patient satisfaction.

- Telerehabilitation Booster Sessions and Remote Patient Monitoring in the Management of Chronic Low Back Pain: A Case Series [*Physiother Theory Pract*. 2018;34(5):393-402.]

    - Conclusion: Patients with chronic low back pain may benefit from the use of telerehabilitation booster sessions and remote patient monitoring in long-term management of their condition.

- Telehealth Implementation in a Skilled Nursing Facility: Case Report for Physical Therapist Practice in Washington [*PTJ*. 2016;96(2):252-259.]

    - Conclusion: Telehealth implementation in a skilled nursing facility for the purpose of physical therapy reevaluation is a feasible alternative to in-person encounters.

- Effects of Physical Therapy Delivery Via Home Video Telerehabilitation on Functional and Health-Related Quality of Life Outcomes [*J Rehabil Res Dev*. 2015;52(3):361-370.]

    - Conclusion: This study of the Rural Veterans TeleRehabilitation Initiative found that homebased telerehabilitation significantly improved functional independence, cognition, and patient satisfaction.

- Effectiveness, Usability, and Cost-Benefit of a Virtual Reality-Based Telerehabilitation Program for Balance Recovery After Stroke: A Randomized Controlled Trial [*Arch Phys Med Rehabil.* 2015;96(3):418-425.e2.]

    o Conclusion: Virtual reality-based telerehabilitation interventions were as effective as was in-person rehab at helping patients recover balance skills after stroke, and at less cost.

- Case Studies in Physical Therapy: Transitioning a "Hands-On" Approach Into a Virtual Platform [*Int J Telerehabil.* 2018;10(1):37-50.]

    o Conclusion: Patients who were assessed and treated for musculoskeletal disorders by a physical therapist via live, secure video reported improvements in movement and function in fewer than four visits and maintained this reduction after three months.

- Telerehabilitation for Treating Pelvic Floor Dysfunction: A Case Series of 3 Patients' Experiences [*J Women's Health Phys Ther.* 2019;43(1):44-50.]

    o Conclusion: Telerehabilitation has the potential to deliver high-quality care for pelvic floor dysfunction and greater access to physical therapists for both initial and follow-up visits.

- Clinical Outcomes of Remote Asynchronous Telerehabilitation Are Equivalent to Traditional Therapy Following Total Knee Arthroplasty: A Randomized Control Study [*J Telemed Telecare.* 2017;23(2):239-247.]

    o Conclusion: Patients who received rehab via real-time video after knee replacement reported similar clinical outcomes and satisfaction compared with patients who received traditional care.

- Efficacy of Home-Based Telerehabilitation vs In-Clinic Therapy for Adults After Stroke: A Randomized Clinical Trial [*JAMA Neurol.* 2019;Jun 24. doi: 10.1001/jamaneurol.2019.1604.]

    o Conclusion: Poststroke activity-based training resulted in substantial gains in patients' arm motor function, whether provided via telerehabilitation or traditional in-clinic rehabilitation.

- Telemedicine and Multiple Sclerosis: A Comprehensive Literature Review. [*J Telemed Telecare.* 2019;May 1. doi:10.1177/1357633X19840097.]

    o Conclusion: For patients with multiple sclerosis, telerehabilitation was shown to be "beneficial, cost-effective, and satisfactory for patients and providers."

- Does telephone-delivered exercise advice and support by physiotherapists improve pain and/or function in people with knee osteoarthritis? Telecare randomised controlled trial. [Br J Sports Med 2020 Jul;54(13):790-797.]

    o Conclusion: Telephone-delivered physiotherapist-led exercise advice and support modestly improved physical function but not the co-primary outcome of knee pain at 6 months.

October 8, 2020

Jeffrey Bailet, MD
Committee Chair
Physician-focused Payment Model Technical Advisory Committee (PTAC)
Assistant Secretary for Planning and Evaluation (ASPE), Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Dr. Bailet,

On behalf of the American Academy of Family Physicians (AAFP), which represents 136,700 family physicians and medical students across the country, I write in response to the request for public comments that the Physician-Focused Payment Model Technical Advisory Committee (PTAC) solicited in September 2020 to inform the role of telehealth in alternative payment models (APMs). The AAFP was an early participant in the PTAC review process with our proposal for an Advanced Primary Care Alternative Payment Model (APC-APM) and remains fully supportive of the PTAC's role in evaluating PFPMs. Most recently, AAFP participated as a panelist on September 16, 2020 during telehealth session. We are pleased to respond to this current request for public input.

**Are there experiences and lessons learned from providing telehealth in existing APMs, such as telehealth in the Center for Medicare & Medicaid Innovation's (CMMI's) current models or APMs implemented by other public (e.g., Medicaid HMOs) and private payers (e.g., Medicare Advantage plans, Special Needs Plans for Medicare-Medicaid dually eligible) that may be informative when developing or evaluating PFPMs?**

There are many definitions of "telehealth," based on services provided, modalities employed, and type of clinician. While these are important facets to consider, we believe a very important distinction to be made is whether the telehealth service is provided by a patient's usual source of care or it is provided by a stand-alone virtual-only clinician. This is especially true in regard to telehealth's role in value-based payment models. We know that primary care is a critical component of delivery models that provide high quality care at lower total cost. Therefore, we believe an important lesson to be learned from current and prior experience is that PTAC should consider telehealth provided as part of comprehensive primary care different than telehealth provided in a virtual-only manner.

Experience has shown that participating in APMs has allowed participants to leverage telehealth and other population health capabilities effectively. Telehealth can enhance success under

alternative payment models (APMs) by enhancing care management and improving efficiency. To date, participants in certain APMs have more flexibility to use telehealth than payers allow other practices. For example, participants in CMS' Next Generation Accountable Care Organization (ACO) and those in two-sided risk under the Medicare Shared Savings Program (MSSP) may be paid for video and audio visits conducted at home and without the usual geographic restrictions in Medicare. However, participants in MSSP with upside-only shared savings and participants in Comprehensive Primary Care Plus do not currently have these flexibilities. The AAFP has long supported adoption of APMs that pay in advance (prospectively) for comprehensive primary care to a family medicine practice's population. In response to the COVID-19 pandemic, public and private payers are altering benefit design and beginning to increase advance payments to primary care practices.

**Are there changes related to the use of telehealth technology, such as changes in scheduling, care delivery workflow, staffing, quality standards, information and supports needed by beneficiaries, etc., that may be required to optimize its use?**

There are many definitions of "telehealth," based on services provided, modalities employed, and type of clinician. While these are important facets to consider, we believe a very important distinction to be made is whether the telehealth service is provided by a patient's usual source of care or it is provided by a stand-alone virtual only clinician. This is especially true in regard to telehealth's role in value-based payment models. We know that primary care is a critical component of delivery models that provide high quality care at lower total cost. Therefore, we believe an important lesson to be learned from current and prior experience is that PTAC should consider telehealth provided as part of comprehensive primary care different than telehealth provided in a virtual-only manner.

In comprehensive primary care, telehealth is a modality of care, rather than a type of care. However, the rapid uptake in telehealth has illustrated the need and role of team-based care in the effective preparation and delivery of this modality. As a different setting or modality of care, it does require some changes to practice processes and workflows to optimize its use. The AAFP has developed a [Telehealth Toolkit](#) that includes information in this regard.
Family medicine has leveraged the care team to develop and implement telehealth in practice. This has required an understanding of the regulatory environment and skills to make it work in practice. Additionally, practices may try a range of approaches, test ideas with their team, and get feedback from patients all while keeping up changes to payment policies across payers. Care team staff spend time with the patient in advance of their appointments to prepare them for the visit. This includes how to correctly utilize the technology platform to avoid any disruptions, including a back-up plan if disconnection occurs. It also includes conduct pre-visit planning to ensure the visit is effective from both the patient and physician stand-point. In a fee-for-service payment model, the technology support and proactive, planned care is not reimbursed, further straining the financial impact COVID-19 has had on primary care.

**Within the APM context, how can stakeholders leverage telehealth to enable coordinated and integrated care delivery for Medicare beneficiaries who need frequent or complex services across a variety of providers? For example, how might telehealth help to optimize care for these patients within and across services and settings such as primary care?**

Regarding primary care specifically, the APM payment construct is particularly important when considering the implications for telehealth in the primary care setting. Ideally, the payment mechanism would incentivize flexibility in care modality, allowing clinicians and their care teams to provide high-value care in the setting most clinically appropriate to the patient. Allowing this flexibility ensures patients retain their continuous longitudinal relationship with their primary care physician.

**In what areas is further evidence about telehealth needed?**

Careful consideration is needed to determine which clinical circumstances should command in-person attention and which cases can be managed just as effectively—and perhaps more conveniently—with a telehealth visit. The ideal combination of telehealth and in-person visits that optimizes efficacy and cost efficiency is not yet known. Physicians will need to determine standards and protocols for which symptoms and conditions can be safely managed via telehealth and protocols should be developed to address the evolving landscape while safeguarding the "Four Cs" of Primary Care: first contact; comprehensive care; continuous care; coordinated care.

Research is needed in emerging APMs to determine where telehealth may improve the ability to share risk and attain quality, cost, and patient satisfaction outcomes. Additionally, clinical and administrative data will need to reflect service modality to evaluate the provision of telehealth services within APMs without adding undue physician burden.

Currently, coding systems do not allow clear designation of telehealth use and many telehealth applications lack integration with the electronic health record. Medical documentation will need to be modified to automatically differentiate care delivered via telehealth versus in-person to allow comparisons in outcomes to be made and to avoid adding documentation burden. Data collection should be automated to the extent possible to reduce burden, and measures should be aligned.

**In the context of APMs for Medicare beneficiaries, what might be the most informative performance-related metrics and strategic approaches for monitoring and evaluating the use of telehealth as part of care delivery?**
a. **Given potential disruptions in claims data due to the COVID-19 Public Health Emergency (PHE), what are the best approaches to constructing benchmarks or comparison groups for payment and evaluation purposes?**

The PHE must be viewed as non-random variation that will likely have an enormous impact on performance. Performance measurement during the pandemic should be used for information only, and should not impact accountability/payment.

b. **What might be the ideal measures and/or measure sets that would adequately detect provider performance and high quality outcomes? What measures/measure sets could inform performance and enable program monitoring on care delivery issues such as access, costs, stinting, etc.?**

In general, existing quality measures should be utilized for both telehealth and in-person delivery to avoid adding burden and complexity. There may be a need for new measures to capture additional quality considerations when telehealth presents a heightened benefit or risk, but in general, services provided via telehealth should be subject to the same quality measures as in-person care and the same quality of outcomes should be expected whether provided by in-person, telehealth, or another means.

The rapidly evolving nature of telehealth may deem it inappropriate to use measurement for accountability purposes until more evidence is built to support appropriate use of telehealth. The variation in terminology used to reference telehealth is problematic when assessing impact of telehealth. Measures need to precisely define which aspect of telehealth is being measured when considering the impact on cost, quality, and experience of care.

The term telehealth has been used to describe everything from generic reminders sent to a cell phone, to the use of video for diagnosing a rash, to a complex system that allows a physician to remotely participate in a robotic surgery. Telehealth can encompass patient-to-provider or provider-to-provider interactions. It can involve synchronous video through computers and mobile devices, asynchronous transmission of video and; remote patient monitoring, mobile health applications, and any combination of these modalities. These multiple confounding factors will make it extremely difficult to develop valid performance measures for telehealth.  At this time the physician is best positioned to determine appropriateness for their patients and staff.

Outcomes of telehealth may be measured in terms of clinical outcomes, standards of care, overall cost, impact on staff and physician workflow, technological issues, and the practice revenue/sustainability. Clinical outcomes, standard of care, and overall cost may be appropriate considerations for performance measures, but structural and process measures that look at workflow, equipment, technological issues, or practice revenue/sustainability are more appropriate for internal measurement and quality improvement efforts.

Cost measures must be able to discern costs that were avoided due to timely access to care (e.g., preventing more costly care, no-show rates that tend to decrease care plan compliance, access to specialty care in rural areas). Analysis must differentiate between telehealth utilization that reflects increased access to care that closes care gaps, decreases net costs, and improves outcomes overall versus unnecessary utilization that adds costs. A broad look at patient and clinician costs should include avoided transportation costs, time spent scheduling, preparing for or waiting for a visit, missed work, child/elder care, missed appointments, technology/infrastructure costs.

**What educational information would you suggest that payers and providers can provide to Medicare beneficiaries and their caregivers to maximize the use of telehealth?**

There are many definitions of "telehealth," based on services provided, modalities employed, and type of clinician, which can be confusing to patients. While these are important facets to consider, we believe a very important distinction to be made is whether the telehealth service is provided by a patient's usual source of care or it is provided by a stand-alone virtual-only

clinician. Patients need to be made aware of these distinctions and understand the care fragmentation that can occur if they receive care outside of their usual source of primary care. Quality telehealth care promises to increase access and mitigate barriers to care for patients, this must be done in support of and integrated within the medical home, not in place of it. Telehealth services in isolation without any regard for previous physician-patient relationship, previous medical history, or the eventual need for a follow-up hands-on physical examination can undermine the basic principles of the medical home, increase fragmentation of care, and lead to the patient receiving suboptimal care.

From an APM perspective, this leads to leakage and potential issues as it relates to attribution. We know that primary care is a critical component of delivery models that provide high quality care at lower total cost. Therefore, we believe an important lesson to be learned from current and prior experience is that PTAC should consider telehealth provided as part of comprehensive primary care different than telehealth provided in a virtual-only manner.

The AAFP provides [patient-oriented information on telemedicine](#) on familydoctor.org.  We believe similar information made available by payers and providers could facilitate use of telehealth by Medicare beneficiaries.

**Ensuring high quality care and access to services is critical for successful health care delivery. What are major telehealth barriers for Medicare beneficiaries related to equity such as access to broadband, technology, or familiarity with the technology, and how might they be addressed? What policies, best practices and technical approaches have providers and other stakeholders used to help mitigate these barriers?**

Telehealth coverage and payment across all payers and lines of business is essential for ensuring that our physicians have the capacity to care for patients in current environment and beyond. Physicians who deliver health care services through telemedicine, as well as referring clinicians and participating facilities, should receive equitable payment for their services to increase the availability of health care services for all children and families. Patients should have access to telehealth services regardless of their geographic location.

**In the context of APMs for Medicare beneficiaries, what federal and/or state policy issues exist that may need to be addressed for appropriate and effective telehealth use, such as Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules?**

Payment policy is one issue that needs to be addressed. Many of the current arbitrary barriers to telehealth adoption are rooted in a fee-for-service payment model. Moving to a model in which most practice revenue is, in essence, capitated makes current barriers like patient location, geography, and type of technology used immaterial. The AAFP has long supported adoption of APMs that pay in advance (prospectively) for comprehensive primary care to a family medicine practice's population.  In a value-based payment model with prospective payments and alignment with goals for quality, the rules are focused on achieving outcomes instead of defining specific allowed structures and processes. This pushes the decision making on what structural and process components are best leveraged to achieve the quadruple aim closest to the patient and clinician, allows for rapid flexibility and innovation.
Telehealth should enhance the physician-patient relationship, not disrupt it. Telehealth policy should promote coordinated and continuing care provided by the medical home and not limit or

steer patients to receive services provided by vendors disconnected from a patient's usual source of care.

We appreciate the opportunity to provide these comments. Please contact Heidy Robertson-Cooper, Director, Division of Practice Advancement, 913-906-6305 hrobertsoncooper@aafp.org with any questions or concerns.

Sincerely,

Sincerely, John Cullen, MD
Board Chair

October 9. 2020


Jeffrey Bailet, MD, Chair,
Physician-Focused Payment Model Technical Advisory Committee (PTAC)
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201
PTAC@hhs.gov


Dear Dr. Bailet,

Thank you for the opportunity to comment on use of telehealth to optimize care in physician-focused
payment models (PFPMs) and alternative payment models (APMs). The National Committee for Quality
Assurance (NCQA) strongly supports PFPMs, APMs and other value-based payment (VBP) models. We
are working on several fronts to optimize telehealth to improve quality in VBPs and other arrangements:

- We co-convened the Taskforce on Telehealth Policy (TTP) that issued a report assessing
  telehealth's rapid expansion during the COVID-19 pandemic and making recommendations that
  specifically address quality, safety and cost issues.
- We updated 40 HEDIS® clinical quality measures to incorporate telehealth as its use rapidly
  expanded during COVID-19.[1]
- We promote use of telehealth and remote care to expand access in our Patient-Centered Medical
  Home (PCMH) and Patient-Centered Specialty Practice (PCSP) programs.
- We and the American College of Physicians developed a "Medical Neighborhood Model" (MNM)
  APM proposal built on PCSPs that uses telehealth for expanded access and e-consults to
  improve coordination between specialists and the primary care clinicians who make referrals to
  them that PTAC recommended for pilot testing.
- We are developing telehealth accreditation programs and systematically reviewing how to
  maximize telehealth in our other programs.

Based all this work, we believe telehealth is health care's natural evolution into the digital age and
another site or modality, not type, of care. It can be as a critical tool in advancing a well-coordinated,
patient-centered and value-optimized health care system. Value-based payment (VBP) models, such as
PFPMs and APMs that hold clinicians and other providers accountable for costs and quality are well-
suited to leverage telehealth's potential. However, one major concern with approaches like capitation or
episodic budgeting is stinting - that providers deliver less care when payments are fixed.

The pandemic related telehealth expansion to date suggests that telehealth could improve access to safe
and effective care, reduce patient barriers and potentially lower cost.

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[1] HEDIS, the Healthcare Effectiveness Data and Information Set, is a registered trademark of NCQA.


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Further analysis after COVID-19's impact recede is, of course, needed, but experience to date has not confirmed concerns that telehealth expansion leads to more consumption of low-value care or fraud, waste and abuse to drive up costs.

Taken together, these facts imply strong synergies between VBP and telehealth, as providers will gain access to new modalities of care that can more easily reach patients (allowing for better population health management) while also providing strong incentives to avoid overuse.

Responses to your specific questions are below.

1. Are there lessons learned from providing telehealth in existing APMs?

Telehealth can and should be an essential tool for maximizing care coordination, access and improved patient experience in APMs. VBP models with shared financial risk and responsibility for improving the health of a population alleviate many previous concerns about potential telehealth misuse, as they allow clinicians and patients to choose the care modalities most appropriate to their needs and preferences. Accelerating VBP adoption across public programs is the best way to expand telehealth to the level currently seen in the commercial market. That is because VBP allows flexibility based on different delivery models, markets and situations.

2. Are there changes related to the use of telehealth technology, such as changes in scheduling, care delivery workflow, staffing, quality standards, information and supports needed by beneficiaries, etc., that may be required to optimize its use?

There are differences in workflows before, during and after telehealth encounters vs. in-person care. For example, telehealth encounters can require getting labs before a visit, ensuring that patients can use and are comfortable with the technology during the visit, and helping patients navigate needed follow-up remotely after the visit.

We should hold telehealth, as another site or modality rather than type of care, to the same quality and safety standards as other care settings. We can and should adapt, rather than reinvent, quality measures for telehealth, as NCQA did this year with 40 HEDIS measures.

We need robust education to help beneficiaries understand how to use telehealth, when it may or may not be appropriate, how to protect their privacy when using telehealth and that they have a right to obtain in-person care if that is their preference.

3. How can stakeholders leverage telehealth to enable coordinated and integrated care delivery for Medicare beneficiaries who need frequent or complex services across a variety of providers?

Telehealth could exacerbate data silos and poor care coordination if it proliferates as electronic health records did with data blocking and interoperability challenges.

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However, because of its digital nature, telehealth also has great potential to improve data sharing and coordination with the right policies in place. It is therefore essential to require accreditation for telehealth with standards that hold providers, plans and telehealth platforms accountable for clear documentation, data sharing with all members of patients' care teams in alignment with 21st Century Cures Act policies, privacy and security. Remote patient monitoring also has potential to facilitate better monitoring of symptoms for patients with chronic diseases than is feasible with in-person care, so allowing APMs to furnish RPM technology should be a priority so they are less likely to need more costly in-person or institutional care. Telehealth's digital nature supports moving move to electronically shared care plans that are particularly important for patients with complex needs. Telehealth also can improve coordinated and integrated care by facilitating e-consults to ascertain in advance whether referrals to specialists are appropriate.

Stakeholders also should note telehealth's beneficial impacts on cost and quality, particularly for patients with complex needs, from:
- Reduced missed appointments which improves care plan compliance,
- Reduced transfers from nursing homes to hospitals and emergency departments, and
- Increased use of transitional care management services that improve outcomes and reduce readmissions, mortality rates and cost.

4.  In what areas is further evidence about telehealth needed?

We need additional research on several aspects of telehealth:
- Its impact on cost and utilization outside of pandemic conditions.
- Its impact on patient safety, beyond providing expanded access that prevents care delays, preventing exposure to pathogens and minimizing travel risks and burdens. This includes assessment of best practices for safe telehealth and guidelines for when telehealth may or may not be appropriate.
- Its impact on quality and outcomes for specific types of providers, patients and conditions.
- Its impact on patient experience and how to leverage telehealth's digital nature to provide more rapid, targeted and actionable patient experience results.
- Its impact on clinician's and other provider's experience, including workflows, efficiencies, best practices, financial sustainability, etc.

5.  What might be the most informative performance-related metrics and strategic approaches for monitoring and evaluating the use of telehealth as part of care delivery?

We should hold telehealth, as another site or modality rather than type of care, to the same quality and safety standards as other care settings. We can and should adapt, rather than reinvent, clinical quality measures for telehealth, as NCQA did this year with 40 HEDIS measures. And we should leverage telehealth's digital nature to help in pilot testing better ways to measure patient experience of health that is more rapid, targeted and actionable than current, largely paper-based surveys.

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6. Are there any measures that are specific to program integrity that are important to consider as it relates to encouraging use of telehealth after the PHE? How, if at all, would these measures be different under FFS or APMs?

Fraud, waste and abuse (FWA) occur throughout health care, including in telehealth. However, arbitrary telehealth restrictions will not deter unscrupulous actors and are not a justifiable or viable program integrity strategy. The most effective approach to aggressively fighting FWA for both in-person and telehealth care is to leverage sophisticated technology tools that can enhance existing program integrity enforcement efforts, and also to drive better collaboration with health care stakeholders.

7. What educational information would you suggest that payers and providers can provide to Medicare beneficiaries and their caregivers to maximize the use of telehealth?

We need robust education to help beneficiaries understand how to use telehealth technology, when telehealth may or may not be appropriate, how to protect their privacy when using telehealth and that they have a right to obtain in-person care if that is their preference.

Policymakers also should develop and prioritize initiatives aimed at addressing the lack of trust and digital literacy gaps that inhibit successful telehealth adoption for patients, clinicians and other providers—with particular focus on populations that have struggled in the transition to telehealth during the pandemic.

8. How might barriers related to the use of proprietary telehealth platforms, software, and tools be overcome to enable their use in care delivery models and APMs for Medicare beneficiaries?

We should require accreditation for telehealth platforms and tools with clear standards for documentation, data sharing aligned with 21st Century Cures Act rules, privacy and security.

9. What are major telehealth barriers for Medicare beneficiaries related to equity such as access to broadband, technology, or familiarity with the technology, and how might they be addressed? What policies, best practices and technical approaches have providers and other stakeholders used to help mitigate these barriers?

It is critical to promptly access lack of broadband, technology and understanding of how to use it so that health care's evolution into the digital age reduces rather than exacerbates disparities. To do this we need to:
- Expand current efforts to ensure universal broadband access.
- Identify and empower caregivers to assist in telehealth delivery
- Allow plans, APMs, clinicians and other providers to give patients technology needed for telehealth.
- Put in place the infrastructure to support the capability to overcome cultural or language barriers and work with ethnic communities and other demographic groups, on both sides of the patient-clinician relationship, to identify and address digital literacy and trust gaps that inhibit successful adoption of telehealth.

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10. What federal and/or state policy issues exist that may need to be addressed for appropriate and effective telehealth use, such as Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules?
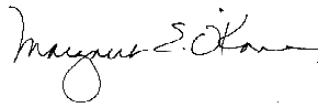
Policymakers should make permanent the following telehealth policy changes enacted during COVID-19 to improve access, patient safety and outcomes:

- Removal of strict limits on sites where telehealth visits may originate, conditions clinicians may treat and which clinicians and providers may use telehealth.
- Acknowledging that telehealth visits can establish clinician/patient relationships as long as they meet appropriate standards of care or unless careful analysis demonstrates that, in specific situations, ensuring patient safety, program integrity or appropriate high-quality care requires a previous in-person relationship.
- Allowing audio-only telehealth where evidence demonstrates it to be effective, safe and appropriate, or where it is likely to be so and offers access to care that would otherwise be unavailable to a patient.
- Allowing asynchronous telehealth (e.g., remote patient monitoring) when it is the preference or need of the patient on a limited basis as more clinical evidence is generated on best practices for ensuring quality, safety and program integrity.
- Allowing insurers to provide telehealth technology, such as smartphones and tablets, as supplemental benefits.
- Allowing telehealth across state lines by considering strategies to expedite licensure reciprocity between states, while maintaining important patient protections and disciplinary tools for bad actors.

Policymakers, however, should reinstate full enforcement of HIPAA privacy protections.

Thank you again for the opportunity to share our thoughts. If you have questions, please contact Paul Cotton, Director of Federal Affairs at (202) 955-5162 or cotton@ncqa.org.

Sincerely,

Margaret E. O'Kane
President

**Better healthcare. Better choices. Better health.**

October 9, 2020

Jeffrey Bailet, MD
Chairman
Physician-Focused Payment Model Technical Advisory Committee
Office of Health Policy
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 415F
Washington, DC  20201

**Re:  Solicitation of Public Input on Telehealth and Patient-Focused Payment Models (PFPMs)**
       *(Submitted via PTAC@hhs.gov)*

Dear Dr. Bailet:

On behalf of more than 9,000 pediatric nurse practitioners (PNPs) and pediatric-focused advanced practice registered nurses (APRNs) committed to providing optimal health care to children, the National Association of Pediatric Nurse Practitioners (NAPNAP) appreciates the opportunity to submit these written comments in response to the September 16, 2020 Physician-Focused Payment Model Technical Advisory Committee (PTAC) discussion regarding the use of telehealth services to optimize health care delivery under physician-focused payment models (PFPMs) and alternative payment models (APMs). These comments are intended to expand upon and amplify the oral comments presented by NAPNAP Health Policy Committee member Kelli Garber, MSN, APRN, PPCNP-BC, at the September 16 meeting regarding the role of nurse practitioners (NPs) and APRNs in providing telehealth services to improve access and enhance value in APMs.

As you know, PNPs and pediatric-focused APRNs are committed to providing optimal health care to children in primary, specialty and acute care settings. APRNs who concentrate on children's care have attained enhanced education in pediatric nursing and health care using evidence-based practice guidelines. They have provided quality, accessible, affordable healthcare to children and families for more than 50 years in an extensive range of community practice settings including pediatric offices, clinics, schools, and hospitals. Practicing in primary care, specialty, and acute care, they diagnose illnesses, prescribe medications and are fully qualified to provide both primary and acute healthcare services to children in a trauma-informed, culturally responsive, evidence-based manner. They are essential providers of care in advanced APMs and innovative care delivery systems.

As evidenced in presentations before the committee, telehealth is an efficient and effective method of care delivery.  It often facilitates overcoming barriers that limit access to care such as transportation, travel distance, missed work or school time, and associated costs. It increases the efficiency of the care system in many ways, including reducing emergency department visits through more timely and effective care. Remote patient monitoring, direct to patient video and phone visits and synchronous care provided to patients in regional telehealth facilities that incorporate tele-presenters and necessary peripheral devices can extend the care continuum.  Ensuring the appropriate cadence of follow up visits and providing ongoing monitoring for certain conditions can improve patient outcomes and enhance the patient and provider experience.

It is critically important that barriers to telehealth utilization continue to be removed, including those resulting from lack of reimbursement. It is equally important that any reimbursement modifications be inclusive of APRNs, including NPs. Nurse practitioners provide quality, comprehensive care. Extending the reach of their care through telehealth can make a significant difference in improving health outcomes and health equity. It is particularly important for NPs in primary care roles to practice via telehealth without physician supervision in order to improve access to care and to enhance the care provided. Including APRNs in telehealth practice can make an APM more efficient and patient centered. As health care continues to shift toward value-based care, it is crucial that APRNs be included in payment models that are flexible, innovative and improve patient outcomes. Telehealth can contribute significantly to the success of these models.

In summary, incorporating telehealth care provided by NPs into APMs increases convenience for patients reducing missed appointments, increases the number and frequency of patient touches and contributes to more real-time awareness of a patient's condition. We believe it is time that we reimagine healthcare rather than simply replicating care over distance. Increasing the use of NPs and APRNs to provide telehealth care can add value to APMs, enhance patient care, improve outcomes and may reduce health disparities. NAPNAP and its members are eager to work with you to identify and implement policies and practices that will increase the efficiency of APMs and expand access to care for patients by eliminating unnecessary regulatory barriers. We are grateful for the opportunity to share our perspective and recommendations.

Sincerely,

*Jessica J. Peck*

Jessica L. Peck, DNP, APRN, CPNP-PC, CNE, CNL, FAANP, FAAN
President

October 12, 2020

Physician-Focused Payment Model Technical Advisory Committee
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave, SW
Washington, D.C. 20201

Submitted via email at PTAC@HHS.gov

RE: *Informing PTAC's Review of Telehealth and PFPMs*

Dear Physician-Focused Payment Model Technical Advisory Committee,

OCHIN is grateful for the opportunity to inform the Physician-Focused Payment Model (PFPM) Technical Advisory Committee's (PTAC's) review of telehealth. When CMS expanded coverage through its regulatory authority and waivers to encourage broad adoption of telehealth for the duration of the public health emergency (PHE), OCHIN quickly engaged with our member clinics to utilize telehealth wherever possible to meet patient needs. While progress was made before the coronavirus outbreak to adopt telehealth, the pandemic has magnified the need to lift boundaries on telehealth services to accelerate its transformational capabilities for patients and providers. We have seen the value of expanded telehealth services first-hand during the PHE and would like to share the lessons we, and our members, have learned. Increased coverage will improve convenience and access to care, result in better patient outcomes, and create a more efficient health care system.

OCHIN is a 501(c)(3) not-for-profit community-based health information technology (HIT) organization, and a national leader in promoting high-quality health care in historically underserved areas across the country. We are a system of over 500 health centers, including Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), correctional facilities, Ryan White Centers, and public health agencies. Many of our health center members provided telehealth services during COVID-19, and fear the cliff looming at the end of the PHE period. COVID-19 has changed utilization of telehealth, with around 38 percent of our encounters occurring using telehealth methodology. While it is important to recognize further Congressional action must be taken, OCHIN strongly advocates for the permanent extension of all PHE expansions for telehealth utilization, including removing all geographic restrictions.

OCHIN Responses to PTAC Questions

*Are there changes related to the use of telehealth technology, such as changes in scheduling, care delivery workflow, staffing, quality standards, information and supports needed by beneficiaries, etc., that may be required to optimize its use?*

For more coordinated and efficient care delivery, telehealth technology must be fully integrated into the EHR. Non-integrated tools are more burdensome to access, require more work on the provider end to document, and therefore are less often utilized. OCHIN uses fully integrated, HIPAA compliant tools to deliver telehealth, and has seen our highest level of telehealth use. Telehealth must also be secure and

private to ensure patients utilize it, as the increased access afforded by telehealth is critical to improving outcomes and overcoming health disparities.

Not only does the telehealth tool need to be fully integrated into the EHR, having external tools that integrate is also key. For example, many patients with chronic conditions require remote patient monitoring (RPM) as a method of management. RPM became increasingly valuable during COVID-19, as patients could be monitored for blood oxygen levels and respiratory function. As an implementer of FCC telehealth grants, we are working to deliver awardees with interoperable and bidirectional RPM tools that provide clinicians with data to best help manage patient outcomes.

Creating and establishing telehealth workflows requires time and resources as well as substantial training sessions for providers and staff. Members required new methods of gaining consent, gathering pre-appointment information, and a reimagining of patient check-in. Quality standards also had to be adapted to understand whether providers and patients were having their needs met. Patient outcomes would be a reasonable indicator of care quality, but for safety net providers who will be losing much of the telehealth coverage afforded to them during the PHE, the short time of consistent use may not provide the most accurate results. In the meantime, patient and provider satisfaction is more easily attained and a good starting point for the benefits of telehealth.

OCHIN analysis shows an increase in compliance rates for telehealth appointments as opposed to in-person appointments. For patients who struggle with reliable transportation, gaining or affording time off from work, or even childcare, attending their virtual appointments takes away many of these obstacles, increasing their ease of access and allowing them to avoid costly trips to the emergency department when symptoms become acute. This increases compliance rates, saving providers money and helping patients to better manage their health.

*In what areas is further evidence about telehealth needed?*

With all restrictions removed and payment parity achieved, research can be done to determine the most effective services that can be delivered via telehealth, the impact on patient and provider satisfaction, and how the increased access can improve patient health, especially for those in remote and generally underserved communities. An extended study must be done on the impact of increased telehealth usage on patient outcomes. This must also include the benefits of audio-only telehealth delivery which must continue to be covered for patients with no access to broadband but still in need of care.

More specifically, we must learn how this truly impacts the health of both urban and remote communities. OCHIN believes that once we have a sense of predictability around telehealth policy, this will be easier to study. Currently, the end of the PHE presents an access cliff, when these flexibilities will no longer be available. Although the PHE continues to be extended to meet the needs of patients, providers knowing there will be an end to this coverage disincentivizes adoption and investment into telehealth.

*What educational information would you suggest that payers and providers can provide to Medicare beneficiaries and their caregivers to maximize the use of telehealth?*

Patients need culturally competent care, in-depth instruction about how to use equipment and technology, information regarding privacy and consent, and how to utilize or access broadband. These systems of support must be well-funded, available to all, and driven with telehealth utilization in mind.

As an organization supporting providers serving many patients who either speak English as a second language, or must be served in their native language, ensuring simple access to translation services and culturally competent care is critical. Telehealth allows for providers to serve patients in any language with access to expanded translator services that can be integrated into a virtual appointment at a moment's notice. With telehealth translators on staff or on call during regular hours, it ensures the patient can have a collaborative session with their provider, and the translator can offer advice on ensuring the care delivered is culturally competent for the particular patient.

Patients often require more in-depth instruction to log into and engage telehealth visits. Many are unfamiliar with the technology and can get overwhelmed by the process, causing them to default to in-person visits. This could be achieved through technological support on the patient end and improved workflows to allow for telephone contact of the patient prior to the appointment and walking them through logging in and activating their session. This not only saves provider time knowing the patient is going to be on time for the appointment, but also reduces patient stress, knowing there will be a system of support when utilizing a new technology.

To improve patient participation in telehealth, patients must be educated on the privacy and security of using telehealth technology to receive health care. Without the utmost confidence in this system, many patients will choose in-person visits over using telehealth. They must also be fully educated on what they are consenting to when participating in a virtual meeting.

Finally, although broadband infrastructure remains an issue, we must assist patients with securing home access to broadband or help them to find a location where they can utilize broadband through a hotspot. Without broadband, the patient population that can benefit from telehealth the most will not have the opportunity to benefit from it. We must expand current FCC programs and increase their funding to improve community connectivity across the nation.

*Ensuring high quality care and access to services is critical for successful health care delivery. What are major telehealth barriers for Medicare beneficiaries related to equity such as access to broadband, technology, or familiarity with technology, and how might they be addressed? What policies, best practices, and technical approaches have providers and other stakeholders used to help mitigate those barriers?*

The major barriers to successful telehealth delivery are broadband and costly technological innovations. Funding must be increased to expand our broadband infrastructure nationally so that every home has broadband connectivity available. This is a necessity not only for health, but for education and economic prospects as well. We need a more organized broadband agency structure, streamlined funding, more competition in connectivity services, and affordable technology on the patient end to close the last mile of the broadband gap. Until we can reach the level of connectivity required to overcome the resulting disparities in health care, telephone visits must be covered permanently to ensure patients with no access to broadband or other virtual means of seeking care can still access the care they need.

Providers then need high quality interoperable health systems that connect directly into the national framework to improve interoperability, ensure every patient has a single record that follows them wherever they seek care, and then ensure providers have the technology and reliable connection they need to deliver successful telehealth care. A program could be created to increase funding and incentives to

ensure all providers, with a focus on mental and behavioral health providers, can get high-quality EHRs. These often provide telehealth capability directly through the EHR by allowing patients to meet with providers directly through patient portal service with the proper accompanying technology.

Additional Telehealth Success Requirements

Beyond the issues touched upon through these posed questions, many other major challenges hinder the expansion and utilization of telehealth:

- Providers require more support to access high quality EHR systems, broadband, and innovative equipment to deliver quality virtual care to their patients
- We must fund and support network operating systems that support 24/7 patient access for technology and support
- All telehealth services must be billable, and geographic restrictions must be removed
- Technical assistance to providers should be a grant funded program and focused on providers with the highest need as opposed to those who can more successfully respond with a grant application
- We must strengthen and augment money going into telehealth resource centers
- Funding must be provided for rural critical access hospitals to participate in new programs and make them sustainable
- Rural care providers must be given the opportunity to scale within a network that crosses state lines and participate in value based payment modes

Thank you for your time and consideration of our comments on *PTAC's Review of Telehealth and PFPMs*. Please contact Jennifer Stoll at stollj@ochin.org should you have any questions.

Sincerely,

Jennifer Stoll
EVP, Government Relations and Public Affairs

Thanks for this opportunity
.I am the rare being known as a solo independent family practitioner, an MD in rural Maine
.There are dozens, even hundreds of us across the country , but we rarely are given a voice.I am
the author of a payment proposal supported by the PTAC as"so innovative we did not know what
to do with it"
To that end-
the country needs help in supporting a failing primary care system.Some actionable things are
never even discussed(call me up) We in primary care ALREADY do telehealth, we just do it
for free, we do it on the phone or by portal.. Video platforms are nice- patients think it is fun-
but the videos rarely add anything to the visit that is medically useful; the videos add a
component of sociability. But the video platforms are also inaccessible
I have been doing telehealth for years with Teladoc. The video quality is NEVER good enough
to diagnose.Here in rural Maine we have a thing called--landlines. Works fine. In the current
system billing for a call is not possible or not worth the trouble(using the chronic care code
requires such burdensome documentation few bother) One can use chronic care codes or try
to figure out at least right now, if CMS waivers regarding covid are still in place. The ordinary
physician cannot keep up of course because medicare does one thing and Cigna another and so
on.
Here in these comments, as in my proposal,I beg you to advance SIMPLE concepts -I know that
simple is hard and complicated but in primary care we are desperate. Telehealth must be
included in a capitated system. You will kill us if we have to have more codes.

Patients have oximeters, bp cuffs, glucometers and nebulizers; because of those things we can do
a great deal more than just check in. To make my patients call their daughter to leave work early
to barely get here in time to see me and oh then the lab or XR or the consultants office to call is
closed , is absurd.We have a system now where all over the country doctors phone in
prescriptions THAT should be forbidden! I do prescriptions when I see and assess. But I can
assess over the phone and know when I have to say sorry you need to come in.
I know CMS is obsessed with fraud- that i snot my area of expertise. Terminally ill primary care
is
To conclude- capitate telehealth into primary care. Quality measures remain burdensome but
unchanged Watch the ER visits and readmits( for the same not just any ) reason. Use Hows
Yourhealth or the IOMs vital signs measures, but of course allow telehealth on a phone line to
replace visits; doctors are more than glad to keep people out of the office- this explands access
for others Thanks
Jean
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Jean Antonucci MD
115 Mt Blue Circle
Farmington ME 04938
ph 207 778 3313   fax 207 778 3544
www.jeanantonucci.com

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*Submitted electronically to [PTAC@hhs.gov](mailto:PTAC@hhs.gov)*

Jeffrey Bailet, MD
Committee Chair
Physician-focused Payment Model Technical Advisory Committee (PTAC)
Assistant Secretary for Planning and Evaluation (ASPE), Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

**RE: Informing PTAC's Review of Telehealth and PFPMs: We Want to Hear From You**

Thank you for the opportunity to  provide comment to inform PTAC's review of telehealth and Physician-Focused Payment Models (PFPMs). We appreciate your leadership in exploring issues, data sources and models that empower independent practices and physicians as we seek to address the challenges of the COVID-19 pandemic on top of existing challenges of patient access, healthcare costs, and provider consolidation.

The Partnership to Empower Physician-Led Care (PEPC) is a membership organization dedicated to supporting value-based care to reduce costs, improve quality, empower patients and physicians, and increase access to care for millions of Americans through a competitive health care provider market. We believe that it is impossible to achieve truly value-based care without a robust independent practice community. Our members include Aledade, American Academy of Family Physicians (AAFP), California Medical Association, Florida Medical Association, and Medical Group Management Association (MGMA). We also have individual and small medical group supporters across the country, many of whom are independent physicians or practices and wish to remain so.

Central to our mission is the belief that physicians – especially independent physician practices– are the lynch pin of our nation's health care system. They have repeatedly demonstrated their superior ability to generate positive results in value-based care arrangements, both in improved health outcomes and reduced costs. In our vision of the future, this important piece of the health care system not only survives, but is thriving as a result of policies that place them on a level playing field with other providers and opportunities to test new models with components that reflect their unique circumstances.

**As an overarching position, we strongly believe that telehealth is simply a care delivery tool to facilitate patient-physician communication. We do not believe telehealth expansion represents a new model of care or payment – it belongs firmly within existing (or updated) alternative payment arrangements that focus on incentivizing value and patient health outcomes.** With this background in mind, we offer comments on the questions posed the questions to the public below.

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**Questions from PTAC**

*Are there experiences and lessons learned from providing telehealth in existing APMs, such as telehealth in the Center for Medicare & Medicaid Innovation's (CMMI's) current models or APMs implemented by other public (e.g., Medicaid HMOs) and private payers (e.g., Medicare Advantage plans, Special Needs Plans for Medicare-Medicaid dually eligible) that may be informative when developing or evaluating PFPMs?*

One of the primary challenges in analyzing the value of telehealth in Medicare is the restrictive regulatory structure around the use of telehealth, even when used within value-based care models that require clinical and financial accountability. Existing geographic and originating site restrictions reflect utilization concerns associated with the fee-for-service (FFS) payment model rather than APMs. Providers in these models are incented to take into consideration the patient's long-term care and spending, and use telehealth in ways that benefit patients without leading to overutilization.

Within value-based care models, telehealth can be particularly useful in facilitating transitional care management and behavioral health services, as two examples. It is a helpful tool to provide transitional care management services – as these services are provided to patients who have just been discharged from the hospital and might not be as ambulatory, as needed for an in-person visit in a doctor's office. Rural ACOs may consider using telehealth in other ways, such as behavioral health, in response to provider shortages or other care challenges in their particular areas.

**We believe that telehealth services should enhance and deepen, rather than disrupt, the physician-patient relationship.** Efforts to expand telehealth should focus on value-based care as an initial use case and emphasize the delivery of telehealth services by existing providers with a longitudinal relationship with the patient, especially the primary care provider. If a visit with a clinician outside the ACO is necessary, there should be clear requirements for sharing information back with the patient's usual or primary source of care. Any effort to expand the use of telehealth in value-based care models like accountable care organizations (ACOs) should apply equitably across models that rely on both prospective and retrospective assignment.

*Are there changes related to the use of telehealth technology, such as changes in scheduling, care delivery workflow, staffing, quality standards, information and supports needed by beneficiaries, etc., that may be required to optimize its use?*

As previously noted, we believe that telehealth should augment existing care delivery structures. It is not a substitute for in-person care in all instances, but rather serves to augment in-person services when appropriate. Telehealth is best used as a tool to support longitudinal, relationship-based care rather than more episodic needs. Standalone, vendor-based approaches to telehealth fail to take advantage of the full opportunity to improve care delivery. A significant concern of independent physicians and practices working in APMs are the potential patient steering effects created by large, highly-visible telehealth contracts with vendors. While it is understandable that many organizations sought to contract with episodic-focused telehealth companies to rapidly scale capability during COVID-19, these arrangements are inferior to models based on a strong, longitudinal patient-physician relationship. Care from outside of the patient's existing care team can be disruptive, particularly when the physician is accountable for patient outcomes under an APM.

*Within the APM context, how can stakeholders leverage telehealth to enable coordinated and integrated care delivery for Medicare beneficiaries who need frequent or complex services across a variety of providers? For example, how might telehealth help to optimize care for these patients within and across services and settings?*

In an APM context, telehealth can be used to facilitate more frequent communication and better care coordination. There may also be efficiencies gained in the recording or tracking of key patient information to share with other members of the care team. However, it is important to note that while telehealth is an effective and meaningful tool that can be used for care coordination and other services, it is not an outcome itself. We do not need new structures, or a "virtual medical home" that is different from existing care coordination models. The payment model is already the catalyst for coordinated and integrated care delivery – telehealth is just an effective and efficient way to optimize care within these models.

*In what areas is further evidence about telehealth needed?*

Continued research is needed to better understand services appropriate for telehealth versus in-person care. The COVID-19 public health emergency has allowed for a direct comparison between the same services offered virtually, or in-person – an important opportunity. In the past, telehealth and in-person services were often not directly comparable. Building on this opportunity, APMs – where the patient can be offered a choice between in-person or virtual care under the supervision of an accountable physician – are an ideal opportunity for continued experimentation with a wider range of virtual services. Services within these APMs are also a good environment for continued research and evidence collection, without some of the potential concerns that would emerge in a FFS environment.

We believe research opportunities exist in the following areas:
- To better understand telehealth usage and outcomes when delivered by physicians with a longstanding patient relationship compared with vendor-driven/episode-based telehealth models.
- The overall impact of telehealth on utilization, including greater clarity on when it is an effective tool in preventing a more costly service and services where it does not add clinical value.

*Are there any measures that are specific to program integrity that are important to consider as it relates to encouraging use of telehealth after the PHE? How, if at all, would these measures be different under FFS or APMs?*

Program integrity concerns that may exist in a FFS model are largely absent from value-based APMs. Incentives for overbilling or inappropriate utilization do not exist in APMs in the same way that they would in a FFS environment. We do not believe that additional program integrity requirements within APMs are needed, and as such, believe that the program integrity checks that exist in the current Medicare program are sufficient to determine fraud and abuse.

*What educational information would you suggest that payers and providers can provide to Medicare beneficiaries and their caregivers to maximize the use of telehealth?*

Patients need broader telehealth education to help them better understand what telehealth is, when it is appropriate to schedule a telehealth visit, and what to expect from the experience. Part of this education should be the understanding of what providers offer telehealth – including an understanding that most of their existing providers can offer telehealth services, even if they do not have the resources to advertise it – as health plans and vendors often do.

We believe physicians and practices leading value-based models incorporating telehealth will be able to naturally provide much of this education, as we expand adoption of these models and align incentives for patient engagement through both office visits and virtual interactions.

*How might barriers related to the use of proprietary telehealth platforms, software, and tools be overcome to enable their use in care delivery models and APMs for Medicare beneficiaries? In the context of APMs for Medicare beneficiaries, what federal and/or state policy issues exist that may need to be addressed for appropriate and effective telehealth use, such as Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules?*

In most circumstances, virtual care platforms serve the physician and meet patient needs. In some limited circumstances, there may be a greater need to ensure adequate data sharing with accountable entities and primary care physicians where it does not already exist.

Another important barrier to telehealth adoption by independent physicians and practices are privacy restrictions on the use of certain communications technologies to interact with patients. During the public health emergency, many smaller offices have relied on tools like Facetime, Skype, etc. that are not fully HIPAA-compliant. We believe that these requirements should vary based on the level of risk and allow greater flexibility in technology for smaller practices without sophisticated telehealth platforms, or when these tools are requested by the patient.

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Thank you again for the opportunity to share our perspective. Please do not hesitate if we can be a resource to you. I can be reached at kristen@physiciansforvalue.org.

Best,

Kristen McGovern
Executive Director