PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE (PTAC)

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PUBLIC MEETING

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Virtual Meeting Via Webex

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Wednesday, September 16, 2020

PTAC MEMBERS PRESENT

JEFFREY BAILET, MD, Chair
GRACE TERRELL, MD, MMM, Vice Chair
PAUL N. CASALE, MD, MPH
JAY S. FELDSTEIN, DO
LAURAN HARDIN, MSN, FAAN
ANGELO SINOPOLI, MD
BRUCE STEINWALD, MBA
JENNIFER WILER, MD, MBA

PTAC MEMBERS IN PARTIAL ATTENDANCE

JOSHUA M. LIAO, MD, MSc

PTAC MEMBERS NOT IN ATTENDANCE

KAVITA PATEL, MD, MSHS

STAFF PRESENT

STELLA (STACE) MANDL, Office of the Assistant Secretary for Planning and Evaluation (ASPE)
AUDREY MCDOWELL, Designated Federal Officer, ASPE

CONTRACTOR STAFF PRESENT

ADIL MOIDUDDIN, NORC at the University of Chicago

A-G-E-N-D-A

P-R-O-C-E-E-D-I-N-G-S

10:00 a.m.

* CHAIR BAILET: Good morning and welcome to day two of this public meeting of the Physician-Focused Payment Technical Advisory Committee known as PTAC.

I'd like to welcome members of the public who are participating today, whether by Webex, phone, or live stream. Thank you all for your interest in PTAC.

If you have technical questions during the meeting, please reach out to the host via the chat function in Webex or email -- and the email address is ptacregistration@norc.org -- with any questions. Again, that's ptacregistration@norc.org.

I extend a special welcome to those of you who are joining us for the first time. Yesterday, we deliberated and voted on two proposals.

And for today, we have organized a number of virtual sessions to gather current

perspectives on telehealth and Alternative Payment Models.

At our last public meeting in June, I shared the new vision statement the Committee has drafted to describe the various ways we see our work as contributing to improving the U.S. health care delivery system.

PTAC is a forum in which stakeholders in the field can convey their ideas regarding new payment and care delivery models that are informed by their experience.

Those of you who tuned in to yesterday's session saw the latest examples of how this plays out.

Our vision statement also mentioned our plans to expand our communications with the Centers for Medicare & Medicaid Services, CMS, and stakeholders in order to further inform policymakers both in and out of government. We are intending to engage in in-depth discussions of important topics.

As the Committee has reviewed the

proposals we have received, we have noted common themes that have emerged across multiple proposals from a variety of stakeholders.

As part of this effort, we have organized today's agenda to explore a theme that spans several past proposals: telehealth.

In response to the coronavirus pandemic, CMS instituted several flexibilities in its regulations pertaining to telemedicine that have enabled an unprecedented utilization of telehealth services, affirming its feasibility and its usability.

These changes are likely to have far-reaching impacts long after the pandemic has passed.

So now is an optimal time to investigate lessons learned from recent experiences and how they might inform future policymaking.

Within that context, PTAC feels that the work of previous submitters, who included telehealth technologies as part of their proposed

Alternative Payment Models, should be looked at with fresh eyes not to re-deliberate on these proposals, but to learn more from the field about how telemedicine may impact Alternative Payment Models, especially given the recent regulatory changes.

In addition to understanding how previous models have incorporated telehealth, we have commissioned an environmental scan on telehealth and payment policy that is available on the ASPE PTAC website on the meeting page.

To offer some context to help frame our discussion, NORC, ASPE's support contractor, will present an overview of how previous models proposed to PTAC incorporated telehealth. Then, we have organized a panel of six previous submitters.

Again, this is not a re-deliberation of their proposals, but a unique opportunity to hear from stakeholders who have been thinking about telehealth and payment policy since long before the pandemic.

After a short break, we will then have a panel of additional subject matter experts to gather an even broader range of perspectives.

When we return from our break, we will have a public comment period to hear additional input and perspectives on telehealth.

Comments will be limited to two minutes each so that we can maximize the number of participants.

If you've not registered in advance to give an oral public comment, but would like to, please email ptacregistration@norc.org. Again, that's ptacregistration@norc.org.

We also encourage stakeholders to submit public comments on telehealth by emailing them to ptac@hhs.gov.

Again, you are welcome to submit public comments about telehealth in writing to ptac@hhs.gov. We intend to post any written public input we receive online.

Finally, we have some time for the Committee to discuss and share any closing

thoughts on the day's events before adjourning.

Taken together, the environmental scan, panel discussions, and public comments are aimed at informing PTAC about the most current knowledge and perspectives on how telehealth itself can be optimized, how its use can, in turn, optimize health care delivery and further the transformation of value-based care with Alternative Payment Models.

A culmination of today's discussions capturing the perspectives we will hear today will be available online in the coming weeks. We have a packed agenda. So I'm eager to get started.

As part of the effort to develop their environmental scan and optimizing telehealth and the interplay of telehealth for transforming value-based care through Alternative Payment Models, NORC reviewed previous proposals that have been submitted to PTAC for evaluation that included telehealth, telemedicine, and/or telemonitoring technologies as part of the care

delivery model within them and interviewed the submitters.

To share their findings about these proposals, I'm going to turn it over to Adil Moiduddin, Senior Vice President at NORC at the University of Chicago, to present.

Adil.

*** Overview of PTAC Proposals with Telehealth Components Presentation**

MR. MOIDUDDIN: Thank you, Dr. Bailet.

I'm happy to present an overview of proposals submitted to PTAC that included a telehealth component.

Next slide. Between December 2016 and March 2020, 36 physician-focused payment model proposals were submitted to PTAC.

Excluding those proposals currently under review, 18 of these proposals included telehealth as a component.

This includes five proposals that included telehealth as a central feature of the proposed model, nine that included telehealth as

an aspect of care delivery or the payment model itself, and four that included telehealth as an optional component of the model or mentioned the potential for using telehealth services under the model.

This presentation summarizes the characteristics of these models taken from an environmental scan on the topic of telehealth in the context of APM[1]s commissioned by PTAC that can be accessed on the ASPE PTAC website at the URL listed.

This work uses the definition of "telehealth" used by the Office of[2] the Advancement of Telehealth at the Health Resources and Services Administration, mainly, the use of electronic information and telecommunication technologies to support long-distance clinical health care; patient and professional health-related education; public health and health administration.

It includes telehealth services

1 Alternative Payment Model (APM)
2 Office for the Advancement of Telehealth

authorized through Medicare as telehealth or telecommunications, which may include live, or synchronous exchange of information, and use of asynchronous exchange of information.

Separately, the definition also includes technologies that create a continuous feed for ongoing analysis.

Next slide. To start with some of the key take-aways, the analysis showed that PTAC submissions with a telehealth component varied by populations served and settings of care.

These submissions envisioned use of different telehealth modalities, with many proposals including more than one telehealth modality.

The submissions emphasized that telehealth is a tool that can be used as part of a broader model to improve access to care and improve quality of care.

And finally, the PTAC telehealth-related proposals incorporated a variety of different payment models.

Taking a step back, the purpose of this analysis is to describe lessons learned from previous PTAC submissions related to telehealth and identify features and common elements across these proposals.

The analysis included a review of the proposals themselves, reports to the Secretary, the Secretary's responses, Preliminary Review Team reports, and a targeted search of other PTAC process documents.

Finally, the broader environmental scan is informed by discussions with 13 of the 18 submitters that proposed a model with a telehealth component that is part of this analysis.

This is the full list of 18 submitters included in the analysis. I'm not going to read all of the words on this slide, but these slides are posted as part of the meeting materials, and there are more details regarding these proposals in the e-scan.

If you're interested in diving into

the details, Appendix 6 -- Appendix C of the e-scan, rather, provides information about each of these proposals and the way they incorporated telehealth.

As noted earlier, these 18 models varied in terms of the conditions and populations they focused on, as well as the relevant settings of care and the proposed telehealth modality.

They address the needs of patients with chronic conditions, emergency care, care for serious illness, primary care, long-term care, and care transitions.

They also encompassed a full range of relevant telehealth modalities, including synchronous telehealth using video and phone, mobile health, remote patient monitoring, and other asynchronous telehealth services.

Proposals emphasized the idea that telehealth is a tool that, when used in the context of a full model, can increase access to, and quality of, specialty care in rural or remote areas; provide enhanced access to providers via

telephone, videoconferencing, smartphone applications, other tools; reduce the burden of face-to-face visits for patients and providers; improve care coordination in care delivery through electronic communication between care team members and specialists; and improve patient engagement using secure messaging and digital communications platforms.

The review also found that PTAC made favorable assessments of the use of telehealth in six reports to the Secretary.

The Committee's remarks emphasize data-sharing opportunities created by health IT and telehealth; noted opportunities to use telehealth to create efficiencies for providers; and highlighted use of telehealth to support higher quality of care, enable earlier intervention, and finally, support reductions in ED[3] visits, hospitalizations and mortality.

I'm going to end here, but there is an additional slide that's posted on the website

3 Emergency Department (ED)

that summarizes the 18 proposals based on their telehealth modality, condition, and setting of care.

And, as a reminder, please feel free to review that, as well as the environmental scan. Thank you.

*** Panel Discussion on Telehealth and Physician-Focused Payment Models (PFPMs): Reflections by Several Previous PTAC Proposal Submitters**

CHAIR BAILET: Thank you, Adil, for that presentation. As Adil said, NORC interviewed 13 of the 18 submitters who had incorporated some type of telehealth in their proposals.

As much as we would have liked to have hosted all of them here today, because of logistical constraints, we've asked six former submitters to join today's discussion and share their insights and lessons learned from the public health crisis about telehealth.

I want to note one last time that this

is not a re-deliberation of their proposals, rather, the information gleaned from NORC's review, and this discussion will serve to inform PTAC on future proposals and its recommendations and comments to the Secretary on physician-focused payment models.

For this panel, we have several questions in the queue for each panelist to respond.

We will work through each question, and PTAC members will have an opportunity to ask any follow-up questions before we move on to the next question.

I'll ask that each panelist try their best to keep their responses to just a couple of minutes or so for each question.

I would like to welcome each of the panelists. You can find their full biographies on the meeting page of the ASPE PTAC website.

CHAIR BAILET: First, I'd like to introduce Dr. Barbara McAneny from Innovative Oncology Business Solutions.

Next, we have Heidy Robertson-Cooper representing the American Academy of Family Physicians.

We also are joined by Stetson Berg from the University of New Mexico Sciences Center -- that's Health Sciences Center.

And next we have Jeffrey Davis representing the American College of Emergency Physicians.

And we also have Dr. Lawrence Kosinski from SonarMD. And finally, we're joined by David Basel of Avera Health. Thank you all for joining us.

So the first question -- what we're going to do is we'll go in order starting with Barbara.

The first question is: Please provide a brief description on how telehealth was incorporated into your proposed physician-focused payment model. Thank you.

(Pause.)

CHAIR BAILET: Barbara, you're on mute.

(Pause.)

CHAIR BAILET: One more time with feeling, Barbara. You're still on mute.

DR. MCANENY: It keeps muting me again.

CHAIR BAILET: I know. There's a gremlin, but hopefully we'll get that fixed.

DR. MCANENY: I'll keep watching. And if the microphone turns red, I'll just tap it again.

CHAIR BAILET: Alright.

DR. MCANENY: So I'm Barbara McAneny.

I'm Innovative Oncology Business Solutions and my proposal was MASON, which stands for Making Accountable Sustainable Oncology Networks.

And this built off the previous CMMI[4] award I had had in 2012 called Come Home for Community Oncology Medical Home where we estimated a savings of about $600 per patient, in cancer patients, by early intervention to keep them out of the hospital by managing the side

4 Center for Medicare and Medicaid Innovation (CMMI)

effects of cancer and its treatment very aggressively so that patients never needed that. We incorporated that into MASON as well.

As we worked through the Oncology Care Model, we found that more important than anything the physician did was the -- whether or not a patient came in with a lot of pre-existing conditions and other problems that made them more expensive to treat.

So MASON is a project that uses the clinical data of 18 contributing oncology practices and the claims data to create accurate target prices for optimally delivered cancer care.

So when physicians are then freed from the concerns about whether the patient I just saw in my office is going to be sicker than most or less, but with an accurate target price, we can really focus on reaching out and making sure that we do the best job we can to manage that patient's care.

So when we started this, telemedicine,

frankly, was not a very useful tool because we were required to have the patient in a clinic in order to use telemedicine, which doesn't help me in this process.

When we were freed up during the pandemic and able to use telemedicine for patients at home, that helped us to have valuable information about those patients to come in. It's a tool to use.

It was especially important when we were able to use the telephone because many of my patients, for example, live out on the Navajo reservation where there is no cellular service, and there is no broadband for using visual telehealth, but we were able to use this modality to figure out who needed to get to the right site of service.

And that is really the key, I think, to health care savings is to use hospitals if and only if hospitals are needed, to bring people into my office if and only if I can't manage what's going on with them at home.

So telemedicine becomes a very valuable tool for us to have more of an assessment.

There's a lot of comment these days about trying to get patients' data coming into the practices, but I think that's only part of the issue.

We not only need the patient experience, but we need a mechanism to evaluate what's going on with that experience to make sure every comment they send us is acknowledged and responded to and managed appropriately.

So telehealth has become a very valuable tool for us in determining which patients need the more important and more advantageous in-person visit. Thank you.

CHAIR BAILET: Thank you, Barbara.

Next, we have Heidy.

MS. ROBERTSON-COOPER: Good morning, everyone. I am Heidy Robertson-Cooper. I'm the Division Director for Practice Advancement at the American Academy of Family Physicians.

In 2018, the AAFP[5] submitted the Advanced Primary Care Alternative Payment Model for PTAC's consideration. In regarding that, our model, it had four distinct payment mechanisms.

It included a primary care global payment. It also included a population-based payment that was prospectively paid and risk adjusted.

There was also a performance-based incentive payment that was reconciled quarterly, and it also included quality and cost measures.

And then last, there were minimal fee-for-service patients -- or, excuse me, minimal fee-for-service payments as necessary for some specific procedures.

Regarding this payment model, telehealth was not explicitly incorporated into the model.

However, making the practice revenue more of a prospective risk adjustment per-patient per-month amount, our model sought to provide

5 American Academy of Family Physicians (AAFP)

practices with the maximum flexibility to deliver care in the ways that most made sense for their patients. And this includes telehealth along with other modalities.

So this approach really drives the idea that flexible payment allows for more flexible ways to deliver care while meeting patients' needs, whether that's in a pandemic or outside of a pandemic, with just regular primary care.

I would say that this is consistent -- this model is consistent with the AAFP's telehealth and telemedicine policy that payment models should support the patient's freedom of choice in the form of services preferred and delivered.

And additionally, we also believe that payment models should support the physician's ability to direct the patient towards the appropriate service modality with adequate reimbursement according to the standard of care.

So we believe that technology used to

deliver these services should not be a consideration -- should not only be a consideration that's included, but it should be what's needed to provide medically reasonable and necessary care.

Now, I'll also state this payment model is designed to be comprehensive and support coordinated, continuous, and comprehensive care. Thank you.

CHAIR BAILET: Thank you, Heidy.

Stetson Berg?

MR. BERG: Good morning, everyone.

The University of New Mexico Health Sciences Center telehealth model was specifically built around the telehealth delivery, and our proposal focuses on remote assessment of neuroemergent conditions and trauma at hospitals that lack neurologists and neurosurgeons. As such, telehealth was integral to our project and our payment model.

We also deliver education to the facilities that we work with. That's about 22

different rural sites.

And we found that in just transportation alone we saved payers almost $250 million over the last five years.

CHAIR BAILET: Thank you, Stetson.

Jeffrey Davis?

MR. DAVIS: Hi, everyone. My name is Jeffrey Davis. Thank you so much for having me this morning.

I work at the American College of Emergency Physicians, or ACEP. In 2018, ACEP created the Acute Unscheduled Care Model, AUCM model, or "awesome" model, we like to call it.

Its structure is to bundle payment model focusing on specific episodes of unscheduled acute care.

The overall goal of the model is to improve the ability of emergency physicians to reduce inpatient admissions and observation stays when appropriate through advanced care coordination.

Emergency physicians in the model

become key members of the care continuum as the model focuses on ensuring follow-up care for emergency patients, minimizing redundant post-emergency department services and post-emergency department discharge safety events that lead to follow-up ED visits or inpatient admissions.

So all in all, the AUCM model provides the necessary tools and resources to emergency physician groups to help ensure that certain patients who otherwise might have been hospitalized and have expensive inpatient admissions, can be safely discharged from emergency departments and overall have positive outcomes once they're discharged.

One such tool that the AUCM provides to physicians is a set of waivers which includes a telehealth waiver that would allow emergency physicians to provide follow-up telehealth services when the beneficiary has been discharged into their home.

The telehealth waiver can also be used when patients are transferred to another

facility.

For example, emergency physicians can use the waiver to follow up with patients who are sent to rehabilitation centers or assisted living facilities that may have telehealth capabilities in place.

And I'll get to that in future questions about the role of the COVID-19 pandemic, but that's -- and how that's kind of changed our thinking of telehealth later on. So thank you so much for having me again.

CHAIR BAILET: You bet. Thanks, Jeffrey.

Larry?

(Pause.)

CHAIR BAILET: We've got to unmute you, Larry.

DR. KOSINSKI: There we go. I think I'm unmuted.

Can you hear me? Can you hear me?

CHAIR BAILET: Yes, we can.

DR. KOSINSKI: Okay. Thank you.

Well, thank you for including me and SonarMD in the proposals this morning that are being presented.

I do believe SonarMD, or the Project Sonar Model, was the first approved physician-focused payment model back in April of 2017.

And it was a joint initiative of the Illinois Gastroenterology Group and Center in the company I founded back in 2016.

In the Sonar model, an attributed population of involved patients proactively receives monthly symptom surveys which are a set of structured questions from a clinically validated index specific to their condition.

They are sent via SMS texting or email, benchmarks are set for the symptom scores and the slopes of change in those scores over time.

The surveys return a symptom intensity score which are then proactively monitored against the benchmarks set by the standard of care coordinators.

Patients who have scores that exceed these benchmarks are contacted virtually and multi-modally by the care coordinators using a structured set of follow-up questions based on the details of their survey.

The results of these care coordinator telehealth visits have been used to create an equally structured alert which is sent to the medical practice.

Guideline-based clinical services are then provided by the medical practice using their traditional workflow on the basis of these care coordinator alerts.

Services can include the typical office visits, telehealth visits, phone visits, and care provided can be testing, changes in medications, procedures, et cetera.

The results of these interventions are then fed back to the Sonar team in a structured fashion to close the alert.

Timely claims data is made available to Sonar so the results of our care coordination

can be then correlated with changes in utilization in cost.

The deployment of the Sonar platform has consistently resulted in significant -- statistically significant savings in total cost driven by an equally statistically significant decline in hospitalizations, ER[6] visits, and outpatient care. Thank you.

CHAIR BAILET: Thanks, Larry.

Last, we have David.

DR. BASEL: Alright. Thank you, Chair.

Again, this is Dave Basel with Avera Health, and our project similarly was based off of a CMMI Healthcare Innovation Award, and our clinical delivery program was called eLongTermCare.

And that revolved around taking a set of very limited resources such as a geriatric-led multidisciplinary team that included social work, pharmacy, geriatric-trained advance practice providers, behavioral health, infectious disease,

6 Emergency Room (ER)

and delivering that into nursing homes via two-way audio/video technology.

And so over the multiple years that this was going on, we ramped up over 75 nursing homes that this was deployed into, and it really enabled us to provide that very limited set of resources.

In our home state of South Dakota, there are fewer than 10 geriatricians board-certified.

And so to be able to provide those limited resources, whether that's infectious disease, behavioral health, and that multi-disciplinary approach in a nursing home would just be impossible on an in-person capability, especially in rural areas and even urban areas.

So by utilizing telemedicine to provide that, we're able to scale that out and provide that to multiple settings.

Not only are we providing in-person care, but we're providing a lot of systematic education in the nursing homes, and we've become

a big part of the quality improvement processes in those nursing homes, which, as we'll talk about later, was key to be able to fight COVID. And so we were really well-situated for COVID.

Still waiting to see the overall CMMI evaluation officially of our programs, but our internal data, we were able to show a 30 percent reduction in ED visits, as well as a $342 per-member per-month savings on the Medicare members enrolled in this project.

CHAIR BAILET: Great. Thanks, David.

We're going to move on to the next question. And there's a little bit here to unpack, so I'm going to try and go slow.

Hopefully, you guys have the questions in front of you as well, but it would be informative to think through lessons learned from the public health crisis related to your proposed model and its components pertaining to telehealth in relation to transforming care delivery, propelling value-based transformation, and enabling provider resilience.

For each of you, given the recent experiences resulting from the pandemic, can you comment on how your telehealth component may inform lessons learned more broadly?

In other words, how might your component and the associated Alternative Payment Model help foster value-based transformation of resilience?

In your opinion, and given your expertise, what are facilitators or key features of an Alternative Payment Model that are particularly important for supporting the telehealth aspects of your proposal?

And finally, under the telehealth-related Medicare fee-for-service waivers implemented during the public health emergency, would an Alternative Payment Model of the kind you propose still be needed? Why or why not?

So I understand there's a lot to unpack there. I'm going to start with you, Barbara, and that gives the rest of the panelists a little bit of an opportunity to put their

thoughts together, but go ahead, Barbara.

DR. MCANENY: Okay. Well, since our savings are predicated on really effectively managing patients at the lowest cost site of service and using higher cost site of services only when absolutely necessary, telehealth can become a very valuable tool.

So with the pandemic, it remained important for oncology practices to manage neutropenic fever because the usual comment of "if you have a fever, stay home," doesn't work for neutropenic patients on chemotherapy. And if they stay home, they will die often in septic shock.

So the question that we had to incorporate into our processes was, how do you keep COVID-positive patients treated and managed without exposing the other immunosuppressed patients in your center, but not letting chemotherapy-induced neutropenia kill your patients?

We also recognize that if our patients

went to the hospital, a cancer patient has a significantly higher chances of contracting COVID and dying.

So we took the assumption that it was our job to our patients to keep them out of the hospital, and to our community to keep cancer patients away from the hospital so they could focus on COVID, and we succeeded pretty well on doing both of those things.

We used telemedicine, and especially the telephonic part, to assess people first. So what we would do if anyone who called up with some -- with a concern about I'm sick, I have a fever, I have a cough, I have any of the COVID symptoms, I can't taste anything, we would evaluate them first by telemedicine.

If we also looked at other risk factors like likelihood of neutropenia or they were having purulent sputum and could have a bacterial pneumonia, we were able to structure it so they would come to the office, be greeted at the door -- if they would text us as soon as they

got there, be greeted at the door, taken to an isolation room where a clinician in full protective equipment would see them and evaluate them.

If they were neutropenic -- everyone got tested for COVID. But if they were neutropenic, they also were started on intravenous antibiotics.

We were able to keep our patients out of the hospital very well. So under the MASON model, that would translate to significant savings.

We did it more because this is a way we could keep our patients safe, and we've actually had pretty good results with doing that.

I think I got all the unpacked parts of your questions. But if I've left anything out, let me know.

CHAIR BAILET: Nice job, Barbara.

And before we move to the next question, I want to make sure that I give our PTAC colleagues the opportunity to ask you guys

questions.

So I'm sure our colleagues are taking notes as we -- as you guys go ahead and answer this particular question. Thank you.

DR. MCANENY: Thank you.

CHAIR BAILET: Let's talk with Heidy.

MS. ROBERTSON-COOPER: Great.

So for the first question around how might anything that we submitted facilitate or help with the lessons or more broadly based on the PHE[7].

So to respond to that, we really believe that the primary feature in our model that would have facilitated that telehealth was a payment methodology which was much less focused on fee-for-service than current payment methodologies.

So for example, telehealth services in our model would have been covered by the perspective risk-based, population-based payment that was represented by what we call the primary

7 Public Health Emergency (PHE)

care global payments, as well as the population-based payments.

So we feel very strongly that if this model were then implemented, that the rapid adoption of telehealth would have been a little bit less rapid because the family physicians would have had the flexibility to provide care by the telehealth modality in advance of the PHE, instead of being prompted by the PHE.

One other thing that I think is important to mention on this is that before the PHE had taken place, telehealth adoption in family physicians was in the low teens.

But after the pandemic was well underway, adoption of telehealth was around 94 percent.

And this was facilitated by some of the waivers, but it's just an indication that if payment was a bit more flexible, then the care delivery would also be able to have been ramped up in this regard.

So regarding the second question as it

relates to the facilitators of the model that are important for the proposal, we think that any APM should be inclusive of payment models that are prospective risk adjustment -- or, excuse me, risk adjusted.

And so again, this mechanism provides flexibility and agility in care delivery meeting both the needs of the patients, as well as what their families and caregivers need.

And then the last question, I believe it was around, you know, because of the waivers that were implemented, obviously the need for payment and some flexibilities around telehealth, is your APM still needed? And, yes, we believe so.

Even with the waivers, the Medicare payment system essentially remains fee-for-service.

And so the PHE has made it very clear that primary care is not sustainable in a fee-for-service environment.

So a primary care payment model that

is substantially less reliant on fee-for-service is absolutely still needed, in our opinion. Thank you.

CHAIR BAILET: Thanks, Heidy.

Stetson?

MR. BERG: Alright. I think I got myself unmuted.

The lack of -- so, what's happening during the public health emergency is the lack of capacity at rural hospitals during this emergency has resulted in a large number of COVID-19-related transfers to the more well-equipped urban areas from the rural facilities.

And the focus of our model on keeping patients at the local centers helps prevent an exacerbation of this problem by reducing the need to transfer neuroemergent patients, and the model could easily be used with other specialties with similar effect.

And something that was great is our bundled payment, we think, is a step in the right direction for health care delivery, in

particular, to the rural areas where these services and communities are avoiding these costs.

And the rural systems that are paying per consult appreciate this, especially those who have very few beds. Some of which have eight beds.

So they're just paying per consult and not a monthly service if they don't use it very often.

Some of the key features for our model is the need for adequate financial support for the consulting physicians, the technology, and the 24/7/365 call center supporting with specialty care.

Another is the focus on the needs of the rural facilities, communities, and patients, which is fostering the retention of the patients in the local area whenever possible, and then they have the option to transfer to the facility closest to them.

As many of you know, New Mexico is a

huge state. So the individuals in the lower or top half of the state may be closer to a different facility than the University of New Mexico.

And then also supporting the focus of the rural facilities on continuing education that we've been providing, which has been increasing the local competency and fostered resilience for those health systems. And I know, for example, tPA[8] administration went up, I think, 20 times during our model.

And is our model still in need of a Medicare payment after the pandemic? And the answer to that is the telehealth-related Medicare fee-for-service waivers did not have an effect on our model.

The only change that was even peripherally related was the inclusion of provider-to-provider consults.

The rates of payment for consulting providers under this waiver could not even

8 tissue plasminogen activator (tPA)

approach sustaining the type of program that we have implemented, and our payment model is still critically needed.

Something that the PTAC model went over with us last year is the payment from the rural sites goes for items that are historically not paid by Medicare fee-for-service, such as on-call availability, the technology platform infrastructure costs, and that will all be necessary to have a way to ensure the amounts that are included in the payment for those costs are appropriate.

CHAIR BAILET: Thanks, Stetson.

Jeffrey?

MR. DAVIS: Great.

So like others have said, the COVID-19 pandemic has really been a game-changer, and the use of telehealth by emergency physicians has really increased significantly.

One major reform that CMS made obviously that's a game-changer was waiving the Medicare originating site and geographic

restrictions.

But in terms of emergency medicine, we also made some waivers that impacted us particularly, including adding the main codes that emergency physicians fail to list of approved telehealth services under Medicare, and allowing emergency physicians to perform the medical screening exam, which is a requirement under the Emergency Medical Treatment and Labor Act, or EMTALA, via telehealth, and that was really necessary.

These actions have really helped preserve personal protective equipment and reduce unnecessary exposure to the disease.

Some of these efforts also aligned with our use of telehealth in the Acute Unscheduled Care Model, the AUCM model, to just following up with patients to ensure that they were following the discharge plan and didn't wind up back in the emergency department or in the hospital.

So I think we have to think more

globally and broader about the use of telehealth in emergency medicine, and it's really -- the pandemic has really kind of opened our eyes in terms of other uses that are broader than just our model.

I think another thing that we've been starting to think about is how telehealth can be integrated into pre-hospital, so EMS[9] care, and we're very interested in seeing how the ET3[10] model plays out in that respect once it actually is implemented.

It also includes access to care in rural areas and in urban areas as well, and it really helps triage patients, which, again, that happened during the pandemic. Triage has been a key feature and key use of telehealth.

I think it's critical in the APM to have that regulatory flexibility to provide telehealth services to patients regardless of where the patient or the provider is located, and to have aligned financial incentives, which,

9 Emergency Medical Services (EMS)
10 Emergency Triage, Treat and Transport (ET3)

again, can lead to more innovative questions.

Now, in terms of whether our model is still needed given all the waivers that were in place during the pandemic, the answer to that, like other panelists have said, is yes. We do think our model is critically implemented.

The specific telehealth waiver may no longer be necessary, again, if Congress and CMS extends these waivers. The originating site and geographic restrictions obviously need Congress to act upon.

So that's something that a waiver would be -- should be necessary under most CMMI models and in our model as well, but telehealth, again, is only one component of the AUCM.

The AUCM includes other waivers and financial incentives that would help improve patient outcomes and lower costs and -- but -- and overall, the model really provides an opportunity to redesign how emergency care is delivered in this country by rewarding emergency physicians who are able to safely discharge the

patients back home and can provide the necessary follow-up care to ensure that the patients don't wind up with a costly ED or inpatient admission.

So there are other financial incentives and waivers in the model that will make the overall goal of the model still very important to play out. So thanks so much again for that question.

CHAIR BAILET: Thank you, Jeffrey.

Larry?

DR. KOSINSKI: The COVID-19 pandemic has reinforced our previous understanding of the barriers to care and the intensified need for telehealth.

When we presented our PFPM back in 2017, we had already documented the fact that patients with symptomatic chronic disease accept their symptoms as variants of normal. As a result, they typically do not seek medical care early enough to avoid morbidity.

We've documented in our proposal that two-thirds of the patients with inflammatory

bowel disease have no documented contact with their provider in the 30 days prior to a hospitalization for a serious complication.

Since COVID-19, this tendency has intensified. Patients are even more reluctant to seek face-to-face medical care due to their fear of acquiring the infection even when they see deterioration in their own symptoms.

Chronic conditions are deteriorating, and patients are presenting even later than in pre-COVID states.

To correct this and produce resilience in value-based care, telehealth must move beyond being reactive care and should be proactive engaging patients even before they realize that they need engagement. This will require changes to CPT[11] codes to allow for proactive care.

Technology is critical. The use of appropriate technology, like our platform, can leverage limited assets to economically and cost-effectively provide an early warning system for

11 Current Procedural Terminology (CPT)

patients with chronic disease. Purely reactive systems cannot provide this.

There is a hunger among specialists to participate in value-based care. These same specialists possess the necessary knowledge to provide that value-based care.

Our physician-focused payment model was designed to create a reimbursement model that would foster the recruitment of specialists.

The most significant facilitator is the financial payment model which should be bidirectionally risk-based, but also include a mechanism for timely ongoing patient payments to the medical providers and manage a population of patients with symptomatic, high variable cost chronic disease.

Practices typically lack the infrastructure necessary for value-based care. The structure of current value-based care for most specialists is typically limited to shared savings which are paid after a study period based on those savings. They typically do not include

ongoing payment. This has limited their acceptance.

During the episode, they are still compensated on a discounted fee-for-service basis which may decrease as value-based care is provided.

This makes the value-based infrastructure difficult to develop, incentives are not aligned, and adoption becomes difficult.

Timely performance data is critical and must be provided by the payer so that practices can monitor their progress in real time. This should ideally be in the form of claims data.

The reason for Sonar's success is due to timely, ongoing payments to the practices and data sharing by the payer.

The Medicare fee-for-service waivers have greatly enhanced the use of telehealth and facilitated its incorporation into medical practice workflow.

This has enabled medical practices to

provide care to patients who would otherwise have been unable or unwilling to receive it. There should be no impediment to a patient receiving needed appropriate care.

As I answered in an earlier question, our model is still definitely needed. Telehealth, as it currently exists, is still based on a reactive health care provision model.

Patients with chronic disease are not consistently able to determine early enough when they are in need of an adjustment in their condition's medical care.

A proactive system is needed so that care can be provided earlier in the deterioration in the patient. This will result in less expensive care.

Expanded use of virtual communications could allow for a structure that can be incorporated into the current system. Thank you.

CHAIR BAILET: Thank you, Larry. Appreciate your comments.

David?

DR. BASEL: Thank you, Dr. Bailet.

First, before I talk about long-term care specifically, I wanted to chime in especially on Stetson's comments about other ways that we've used telemedicine to handle a public health emergency.

And so we've really ramped up our efforts and created a hospitalized home telemedicine monitoring program and kept, you know, hundreds of patients out of the hospital through that, including patients on oxygen and stuff. So that really accelerated some of that as well.

And we also have an e-hospital program where we've got hospitalists deployed to a lot of our rural hospitals via telemedicine that enable our rural hospitals to keep a lot of patients that otherwise would have ended up in a tertiary and quaternary centers and probably would have doubled the volume of patients that we are seeing.

And so this has been such a blessing

to have some of those technologies in place for us.

In regards to long-term care settings, I mean, obviously nursing homes have been on the front lines of the fight against COVID.

And we were uniquely situated already having a presence in so many nursing homes at the beginning of this, and we got quickly accelerated requests coming in the beginning of COVID.

And so now we've more than doubled to 150 nursing homes that we are delivering services to right now, but it's not just the in-person care.

So providers weren't being able to come in and see their patients. And so that direct patient care via telemedicine has certainly been critical to this and been a bridge until physicians and other providers can come back into the centers.

But it's also been we've always looked at our programs as a facility-wide cultural transformation.

It's not just good enough to come in and be able to bring a patient up on camera and say, yes, that's cellulitis.

What we found early on 10 years ago when we started with this concept, is that you get those calls too late.

They've delayed care, and they're already septic by the time the nursing home calls you.

You have to change the culture in that nursing home, and that's a system-wide intervention.

We've always been involved with kind of three legs of our intervention. One, only one of which is that direct care. The other two are that education and involved in that quality project through that cultural transformation that's needed.

And so that's been another very good use of our program during COVID because we've been intimately involved with those centers as we are looking at COVID, whether the policies,

infection control, prevention, cohorting, all of these things being involved in that and being able to rapidly intervene in those settings when they do get a positive and move to an outbreak type of situation has just been keen to our response in all of those.

And that answers the question of is it still needed even with the telehealth flexibilities during that?

You know, telehealth flexibilities are still a very episodic, you know, point-in-time payment for specific things. They don't cover these facility-wide interventions and the culture change and stuff.

Yes, there's nursing home quality programs, but those effects are so minimal overall.

And so two-thirds of the things that we've done during the pandemic are still things that aren't covered underneath those telehealth flexibilities. So yes, it's still needed.

CHAIR BAILET: Thanks, David.

And so I'm just going to summarize some of the things I heard and then open it up to my colleagues to comment.

One of the -- Barbara's point about flexibility on the clinical redesign, so on-the-fly they had to marshal telehealth to really keep patients out of harm's way and essentially redesign the care delivery under the circumstances of COVID, but I also heard from Heidy about flexibility in payment.

So if you have an underlying payment model that has telehealth incorporated in it, it allows the flexibility to leverage it when you need it, but it's not a one-off.

It's actually just built in, it's re-engineered into the practice, and that payment facilitates that, and that flexibility is important.

The proactive point that Larry raised, I thought, was very interesting in that really the backbone of your model, Larry, Project Sonar, was obviously monitoring -- continuous

monitoring.

But it really became evident, as you described it, that given the reluctance of patients to -- even when they have symptoms that they think warrant a follow-up or a visit or a conversation, without that monitoring because of the reluctance, it has the opportunity to progress.

So telehealth really -- that proactive continued outreach really helps break down that barrier especially when patients are very sensitized to going into facilities right now on the backbone of -- in the backdrop of COVID.

Jeff, you talked about follow-up. And I know that ER follow-up, the physicians calling the patients, was critically important in your model, and clearly it continues to be so right now under the circumstances with COVID.

And I liked your comment about preserving PPE[12]. That was an angle that I certainly didn't think about that I thought was

12 Personal Protective Equipment (PPE)

pretty important here.

And then, David, your point about, you know, right now telehealth is -- it's still sort of an event, you know. Okay, I'm going to turn it on, or I'm going to go ahead and use it.

It's not looking at the whole system holistically yet, meaning, the true value of what it brings.

Right now, the only value that's delivered is when it's used to some extent if it's not built into a model, but a payment model, as you've described it in your setting, if it actually would incorporate telehealth as just a component and a value add, I mean, you don't get paid per click, but you just -- you get paid for the outcomes, and telehealth is a component of driving those outcomes.

Those are some of the things that we heard in the answers to this particular question. I'm going to go ahead and open it up to my colleagues now.

Are there any additional questions,

follow-up questions that you guys have? Otherwise, we can move on, but I just wanted to make sure.

DR. SINOPOLI: So I had a question -- a comment and a question.

Can you hear me?

CHAIR BAILET: Yes. Yeah, go ahead. And then, Lauran, you can follow up after Angelo.

DR. SINOPOLI: Okay. So first of all, I just want to congratulate everybody as I sit and I listen to how you've used telehealth in all of these -- a variety of arenas.

I wish I could incorporate all of those across my entire delivery system because that would create a true integrated delivery system using telehealth through every aspect of care that I can think of across personal health. So all of those are great.

A question I would have, and I guess mainly it's around primary care and emergency room care, is so the technology for telehealth, although there's still some barriers as we know

in terms of just access and broadband access, et cetera, that's become less of a barrier as the technology has improved.

I'm wondering what kind of barriers you might have faced in terms of just operational workflows in your practices and in the emergency room, and have you identified ways around those and best practices in terms of how you're delivering that telehealth operationally with your physicians, and is it just worked into their daily schedule, incorporated into their regular patient list, or are you isolating times during the day or the week to have dedicated people doing this, or what are some of the best practices that you've been able to identify?

CHAIR BAILET: Anybody is welcome to -- David?

DR. BASEL: Yeah. So for our model, that's the whole reason why we had to scale up a bit because it's really hard to do this.

I got to have one patient that, you know, I'm managing via telehealth, the next one

is this way, because the need is when the need is in nursing homes.

And so we created a multidisciplinary model that's totally dedicated to eLongTermCare in the nursing home.

So 24/7 we've got somebody only doing that so that they're available at all times because that's part of that cultural change in the nursing home as opposed to the old model that, you know, where I would tell the nursing home as a primary care physician, don't you dare wake me up unless it's an emergency.

And so then they put it off until it's too late, you know. We're changing that culture to, hey, eLongTermCare, we're here, we're up all night anyway, give us a call type of thing.

And so we just -- but you've got to get the scale. And so it wasn't until we got the, you know, 60-plus nursing homes where we were really taking full advantage that you could have somebody full time and a whole team of people, you know, your social worker, your

behavioral health people.

And so you've got to get the scale to be able to do that, which is a barrier.

CHAIR BAILET: Jeffrey, were you going to say something?

MR. DAVIS: Yeah. I was just going to say, you know, cost has been a major barrier in getting the telehealth programs in emergency medicine up and running. And I think some reimbursement under the pandemic -- and I just think financially it's been really helpful.

It also, like what you said, it takes a culture shift. Emergency physicians, you know, have to go on shifts, and they're busy in the emergency department, as you all know.

And then they go home and, you know, I mean, the transition of care in the emergency department is difficult.

And that's why a lot of times patients who are discharged and got lost in the system. And I think that's the value of our model.

And during the pandemic, I talked to a

Chief Medical Officer on the West Coast, and he's making an investment in this group to make sure that they -- if during that shift, if, for some reason lines are down -- and they have been down in the emergency department during -- in some cases, during the pandemic, they take actual time out of their shift to follow up with patients they've seen in previous shifts.

I think that time investment and that culture shift is going to be critical in emergency medicine.

CHAIR BAILET: Thanks, Jeffrey.

I know, Heidy, you're going to make a comment. Lauran, you have a question, and then Jen has a question as well.

So Heidy, please.

MS. ROBERTSON-COOPER: Alright. Thank you.

So primary care and family physicians generally have had to completely re-engineer their clinic workflows to adopt telemedicine in their practices.

So they've really had to lean on their care teams not only to, you know, understand and implement virtual or telehealth visits, but preparing the patients for a successful and helpful visit to them.

So there's preparing the providers, the clinicians, if you will, but also making sure the patient has what they need in order for a successful visit all around.

So we've seen a lot of pre-visit planning taking place, reviewing schedules in advance, having pre-telemedicine visits to make sure that the patient understands how to utilize the technology. And if not, having a backup plan for an audio-only visit.

And then they've also had to really think about when you use telemedicine versus when that patient needs to come in and have an actual in-person visit.

So there has been a lot of additional practice and use of the care team to really help support the visits that the patients and

physicians are needing to take place from both an in-person and telemedicine standpoint.

CHAIR BAILET: Great. Thank you, Heidy. That was very helpful.

Lauran, your question?

MS. HARDIN: Heidy, that was a perfect lead-in to what my question is. Thank you for these excellent innovations and presentations.

In my work with the National Center for Complex Health and Social Needs, I engage with communities around the country.

And what I watched happen with COVID is a tremendous shift to everyone shifting to telehealth in all disciplines.

So a tremendous interprofessional shift: nurses, social workers, community health workers, behavior health, addiction treatment.

I'm curious if each of you would have a comment about what payment and policy shifts would you like to see or have you learned from utilizing an interprofessional team delivery of telehealth.

DR. MCANENY: Okay. This is Barbara. I will jump onto that.

I think we are all very enamored with telehealth right now. It kept our patients safer, it kept us safer, but I think we need to proceed with some degree of caution.

A telehealth visit is not as good as an in-person visit because the physical examination still has significant value.

And there are some interventions, such as delivering a liter of saline to keep someone dehydrated out of the emergency department, that you simply cannot do through telehealth.

I think we also need to be very careful about not exacerbating health disparities for those who cannot afford a smartphone or do not have a computer and for people who are sick without a caregiver to set up the telemedicine visit.

I agree with the previous comment that it takes a lot of prep to set that up for the patient part.

We know all the Zoom meetings start with "Can you hear me now?" Well, so do the telemedicine visits.

And so you know, in MASON one of the things that we recognized early is that if you can incorporate into the payment processes the increased costs that occur for more disadvantaged populations, for people who are unable to come in, people who have no caregiver, which we found was a major cause of emergency department visits, then you can stop worrying so much about whether or not you're going to be penalized for taking care of that patient, but be able to use the tools that are available appropriately.

So after the pandemic, I think we absolutely should continue being able to be paid for a telehealth visit with the patient in their home, not necessarily in another clinic where I don't actually need telehealth.

Being able to be paid for the telephone visits are very useful with the caveat that they're not quite as useful as the other

modalities.

And I think we need some guide rails around because the last thing we need in a country with an opioid epidemic is opioid-prescribing telemedicine doctors from elsewhere out of state coming in and providing, quote, services, unquote, to our patients.

So there are some -- we can't lose track, in our enamored state of love for telemedicine, that there are some pitfalls here that need to be carefully considered.

CHAIR BAILET: Thanks, Barbara.

I want to get Heidy and then Jeff, and we'll move on to Jen who has a question. Thank you.

MS. ROBERTSON-COOPER: Thank you, Dr. Bailet.

So what I would say, from a primary care perspective, is that historically primary care has been undervalued. There's a lot of research that points to that.

And so to have a comprehensive primary

care team inclusive of an interdisciplinary team that you are talking about of social workers, community health workers that can really help wrap all those services around patients, it is just not paid for in the current system.

The APM that we have proposed is an increase in primary care payment as it's currently paid today. So it's looking at 10 to 12 percent of spends instead of about six percent of priority spending.

And that increase in spend will help family physicians and their care teams really provide the services that the patients need holistically not only in the practice, but also in the community coordinating with specialists, pharmacists, and others.

We do think that the APM, the prospective risk-based payment model, will help with those services. So that's how our APM would fit into your questions.

CHAIR BAILET: Thanks, Heidy.

Larry, you had one comment that you

wanted to make before we move on to Jen's question.

Could you do that, please?

DR. KOSINSKI: Yes.

I would like to build upon something Heidy said. Just about every statement she made about what's happening in the primary care practice is also happening in the specialty care practice.

We have to have three televisit visits with staff and then post-visits with staff. This has become a team solution.

And we have to work harder on improving and increasing context for care rather than imposing all these restrictions that we've been living with in the past.

We need to make it easier. These are low-cost services that avoid high-cost services, and we can't be penny-wise and dollar foolish. We have to pay for principal care management, which is a team-based approach.

CHAIR BAILET: Thanks. Thanks, Larry.

Jen?

DR. WILER: Thank you, again, to everyone for being here today.

I know we're using the word "telehealth," but really what we're describing are virtual care services.

And when we think about, you know, payment policy there, we're starting to -- there's some discernment between those two. So I just wanted to state that.

I'm curious -- I want to give you the opportunity to talk a little bit about -- we discussed maybe some challenges -- and, Dr. McAneny, thanks for bringing this up -- around hardware and software and equipment issues.

And so not only acknowledging those two different requirements, there's also the who pays for it, who maintains it, in addition to the services that are being provided over the platform.

I'm curious your thoughts either, you know, that allow you to expand around what are

those challenges related to the implementation, the maintenance, or the cost, especially as we are thinking about this continuum of care ambulatory to inpatient, back to ambulatory, and maybe to the facilities in the ambulatory space and what are the implications from a policy perspective and opportunities for innovation.

There will be many who are listening here. And so I think your expertise in identifying gaps also could help us spark innovation in this space. Thank you.

DR. MCANENY: So I'll address that. My practice implemented -- this is my personal practice, not all of MASON, but implemented telemedicine in four days, and it was very expensive because we had to take the HIPAA[13]-compliant process that was available, too, at the time. It is not inexpensive. It does not cut down on staff time.

However, in the MASON model and in many of the payment models that are being looked

13 Health Insurance Portability and Accountability Act (HIPAA)

at by PTAC because we're away from fee-for-service care, then office visits and patient interventions, frankly, become an expense line item rather than a fee-generating event.

So if you're trying to manage the entire cost of care to a target price -- obviously, I believe first you need a very accurate target price or you're doomed to failure -- you need to not penalize physicians for taking care of patients who have adverse social determinants, adverse comorbidities, et cetera, which many of the current models do.

And we need to be able to then look at all of these techniques and tools that we use in basis of which one is the most cost-effective way to manage that patient and to deliver to that patient what they need at that point in time, because we have all learned that if you don't provide those services to that patient when they think they need them, they will seek them at the higher site cost of care.

So we need to make sure that we use

telemedicine wisely like any tool. No one has big discussions on how I employ my stethoscope, but we do have these discussions because we get paid differently for them.

So I think we need to very carefully embed them and recognize that if we can make it less expensive by keeping these tools at a minimal cost, if we can do accurate cost accounting, which is, frankly, the basis of MASON, to be able to say this is the cost of a 15-minute visit with telemedicine with the patient, and not disadvantages the practices by paying less than the cost of delivering the service, then I think you've added another important tool to our toolkit.

CHAIR BAILET: Okay. Thank you, Barbara.

Larry, I know you had raised your hand.

DR. KOSINSKI: Yes. A short addition.

We have been working very diligently on developing the cohort science behind getting

patients to respond.

We have to recognize that there are a myriad of differences amongst the patient population.

Some patients are fearful of electronic transmissions and fearful of telephonic visits.

There are others that lack the infrastructure, but, over and above that, the personality differences amongst patients creates sets of cohorts that need different types of approaches to engage them.

And I think it's critical that when policy is being made, that we are allowed some latitude to build the science that needs to be built here so that we can communicate with patients the way they want to be communicated with in a timely fashion so we can get these diseases before they get the patient.

CHAIR BAILET: Excellent. Thank you for that. This is a great discussion.

Grace, you had a question?

VICE CHAIR TERRELL: I do. And I want to direct it specifically to David and Stetson. And this has to do with the fact that there's certain populations, and you both spoke about it, where telemedicine or virtual care requires a cooperating entity on the other side that may or may not be the patient.

So within the context of long-term care, David, and I know Avera has substantial experience with that, quite often part of the issue on the other side in a long-term care setting will be do you have a facility who is willing to host telecare because you may not have a resident in the facility who actually can -- neurologically or with other impairment from sight or vision or dementia or whatever, cannot actually do a televisit by themselves.

So there's Q codes out there right now, but my understanding is very few of the skilled nursing facilities knew that were out there to help support telehealth on their side in terms of the expense, you know, when this

pandemic made it such many of them wanted to suddenly or had to use it.

Likewise, Stetson, when you talked in the past about what University of New Mexico has done in rural health, a lot of your payment model was about incentivizing both sides, both the rural hospital, as well as incentivizing so that you could have a surgeon on call taking those calls.

So my question is very specific for the two of you, which is, if you all were thinking about your payment models in the past, both of you, I think, had to think through the economic incentives in a fee-for-service way, at least if there was reimbursement from two different types of health care entities, to make the advantage of telehealth work.

Given what just happened with the waivers, how should we, as we're thinking about this with advanced Alternative Payment Models that tend to be just physician or provider-focused, be thinking about these issues of how to

actually incent the entire ecosystem, particularly when it requires both entities to be incented?

I can see this also being the case in the emergency room settings as well.

DR. BASEL: I can take first stab at that.

From my standpoint, it's the complexity of that billing that's the biggest barrier there.

And I think we're going to talk about this a little bit, but, you know, for a multidisciplinary approach like ours that's got social work and it's got pharmacy and it's got geriatricians and family practice providers and such, you know, every time one of those got on camera, we have to bill separately for that event and the nursing home have to originating origin fee for every one of those events.

And then we have to figure out how to bill those multitude of events, let alone the fact that we're not going to be able to bill for

all the system-wide type of interventions that are episodic in nature like that. That complexity is just such a huge barrier.

And then the patient co-pay is something that you can't underestimate. So if we start, you know, piecemealing bill for this, bill for that and bill for that and there's a patient co-pay for every one of those, and so many patients in long-term care are on fixed income and they're saying, wait, what am I getting all these bills for? It's just too much.

And so you know, frankly, we're in a subscription-based model right now where the nursing homes pay monthly fees just to cover all of that so that we can remove all of those barriers, and it's worked a lot better that way, which brings us back to the need for more of a risk-based payment because then you don't have to put up as many rules around billing and stuff because you're getting the billing through the shared savings and stuff, and it just cuts through all that type of stuff.

And then that allows for the facility-wide interventions and all of that, you know, just goes away.

CHAIR BAILET: Thank you.

Stetson, did you want to add something?

MR. BERG: Yes. I definitely want to echo what Dr. Basel was saying, and I completely agree that we had to figure out how do we make this work and not complicate sort of the payment from the hospitals that we're working with so that way we're not trying to receive the insurance information appropriate for billing and then they get two bills or what have you.

And some of this I was prepared to address in the barriers question, but I'll -- because these are all excellent questions from the panelists, but I'll try to speak to that a little bit right now.

Certainly the lack of reimbursement from Medicare and private insurance comes up as a barrier to a lot of the health systems.

There's a lot of other rural facilities that might be using telemedicine and they maybe are paying for several fees -- so, the implementation fee, a periodic subscription fee, a physician on call, equipment maintenance, et cetera -- and we didn't want to complicate that either. So that's why ours is a higher per-cost consult fee.

And so that makes it a lot easier, like I said, for the system to maybe use this a couple times a year.

They're not paying all year for the service. They pay once. And so that has been initially a concern with a lot of health systems.

They look at the consult cost and, you know, their eyes get big. And then when they realize that, you know, that if they're not using it, they're not paying, it's been fantastic for a lot of systems.

And I can talk a little bit about that more later, but also the intricacies of the University of New Mexico is the largest health

system -- or at least the second largest health system, I think it depends on how you look at -- in New Mexico and trying to balance the coverage of our practitioners as well.

So they obviously have on-call schedules for this, and then there's also ad hoc. And we also contract with kind of a provider pool to make sure we can get to these systems within 15 minutes of a consult. So sometimes credentialing.

And I would say another thing that would be fantastic is that we're seeing them move towards the HIE[14]s.

And so for us it's been difficult since most the time the patient doesn't actually come to UNM[15] to track patient record outcomes or transfers because they never enter our system. So you know, some of that is tackled by having direct access to those health systems.

But when you have 22 rural facilities that use a variety of different health

14 Health Information Exchange (HIE)
15 University of New Mexico (UNM)

information systems and, you know, products -- I don't think anyone user Cerner like we do -- it's quite the challenge to track the patient and look at the things that we'd really like to to be able to give a really good answer for you, Dr. Terrell.

VICE CHAIR TERRELL: Thank you.

CHAIR BAILET: Thanks, Stetson.

This has been a great discussion and we have more questions than time to -- unfortunately.

So I want to make sure that we at least cover the material, and one of the things we sort of touched on already are barriers.

We talked about, you know, challenges with co-payment, challenges with technology, challenges with the actual payment model and flexibility.

And I know all of the panelists were really asked specifically to prepare for discussing barriers.

In addition to what's already been

talked about relative to barriers, are there other barriers that you would want to bring forward before we go to the last question? Then I'll have all of the panelists answer.

So anyone has any other barriers that they'd like to share or lessons learned around those barriers, that would be great.

David, I see you raising your hand.

DR. BASEL: Yeah. So I think this will be one that all of us will probably agree with, and that's the interstate licensure and credentialing issue.

And so we're in, I think, 11 states now. And as a physician, you know, I'm surprised that my fingers aren't black from having to take my Homeland Security fingerprints, you know -- the same exact thing from Homeland Security every week for another state as we add them.

And, you know, how is that adding any value? It's just an unnecessary barrier, in my opinion.

And so anything we can do to

streamline that process across states and make it uniform would be very helpful.

CHAIR BAILET: Thank you.

Heidy?

MS. ROBERTSON-COOPER: Sure. I would just say -- I know coding was brought up, but I would say the lack of alignment between payers on their telehealth policies.

Family physicians, on average, have about 14 different payers that they're working with. And each one of those payers has their own, you know, what they're covering, what the waivers are, what codes to use, what modifiers.

And it has been a nightmare, quite honestly, for family physicians to help navigate that and understanding if they can get paid, if co-pays are waived for their patients and how to engage with them when they're already in a stressed environment.

So I would say the lack of alignment on telehealth payment policies has been a big barrier for primary care.

CHAIR BAILET: Thank you.

MR. DAVIS: This is Jeff Davis.

Just to add onto that, I think that has been a big barrier in emergency care as well. And also, just a lack of certainty about the future.

So what happens once the pandemic ends? Are these finance incentives still going to be in place? Are these waivers going to be -- is Congress going to take up originating site and waive originating site and geographic restrictions?

So you make this huge investment, and you talk about cost being a major barrier. And a study came out of emergency medicine that cost is a major barrier to setting up emergency telehealth programs before the pandemic. So what happens once the pandemic ends?

Those programs that were established for the pandemic, are they going to go away? What happens to them? I think the lack of certainty is really a big barrier as well.

CHAIR BAILET: Okay. Thank you.

DR. MCANENY: I would agree with that, and I think we cannot avoid considering the fact that bandwidth is now in the health infrastructure.

And places that have inadequate bandwidth are really going to exacerbate health disparities.

We also tend to assume that everyone is very tech savvy. My patients are not all that tech savvy.

My Sandia National Lab physicists are, but a lot of my elderly patients, if they do not have a caregiver who is tech savvy, the telemedicine visit is very unsatisfying from both sides.

I think that the rising area that we will have to consider in the future will be the liability issues and, again, I have concerns about the across-state line.

If we just open up telemedicine so I can sit in New Mexico and prescribe for someone

in New York that I've never had a relationship with, I think we are setting ourselves up for disasters.

So I think we need some strict regulation that says you have to have a pre-existing patient relationship or you have to be talking to one of those patient's physicians for, like, the telestroke help, so that we can help protect patients from charlatans who can log in and convince them to buy all kinds of things, and they tend to believe people who are wearing a white coat.

CHAIR BAILET: That's a great point, Barbara. That's very helpful. Thank you. This has been really informative. I've been enjoying the discussion.

I also want to be respectful of time, so I'm going to move to the last question and then just sort of cycle through all of the panelists.

And the last question is simply this: What are the most critical insights that you

would like to share with regard to telehealth and Alternative Payment Models and the relationship between the two, and their implications regarding high-quality care, optimal outcomes for patients, and the transformation of value-based care? What are the key features?

So some of it we've touched on, I know, but this is sort of your ability to sort of take us home, starting with you, Barbara.

DR. MCANENY: Okay. That gives other people more time to think. It's hardly fair.

(Laughter.)

DR. MCANENY: So the first thing, I think, is accurate cost accounting. Really, this is what MASON is built on, and I think this is one of the flaws in our health care system is that we do not really know what it costs to have a patient in an exam room for 15 minutes, on a televisit for 15 minutes.

We don't know our costs and how can industry -- any industry control costs if we don't know them?

So as we implement telemedicine, which is a tool, it is not the savior of health care, it is a tool. We need to embed in that very careful cost analysis so that we pay fairly for these services, that we don't disadvantage them, and that we don't disadvantage other services.

We have to recognize that there is a continuum of modalities of ways for us to deliver care.

And we have to look at what is the appropriate use of each of these tools that we have at our disposal and use them wisely and use them appropriately.

We are just at the beginning of this journey. I think it will take a lot of information coming from the field of people who are using this every day in its various settings, and I think that the key flexibility to allow us to use these tools is also important. Thank you.

CHAIR BAILET: Thank you, Barbara.

Heidy?

MS. ROBERTSON-COOPER: Okay. So when

thinking about telehealth, the AAFP doesn't think about it as one thing. We think of it as two domains in two different delivery models.

So there is the direct-to-consumer telehealth delivery model, which is exactly what it says, but we also see it as fragmented and uncoordinated care.

We see that as one telehealth model, and then we see telehealth as a modality in a comprehensive primary care setting that's provided by their usual source of primary care that is ensuring that the care is continuous, comprehensive, and coordinated.

And that's really where the Academy sees telehealth as part of a tool to use, that's already been said several times, not as a standalone modality.

And in order to do this and for primary care to be successful in supporting not only this modality, but being more comprehensive and meeting patient needs more holistically, we need flexible payment and delivery models.

And, again, I think our APM that we submitted in 2018 really gets to that in the form of prospective risk-adjusted primary care payments.

We know that the need for flexibility is not new, and it will not disappear after the pandemic.

So we really think that providing those prospective risk-adjusted payments will allow primary care to be more responsive to patient needs in no matter what setting.

CHAIR BAILET: Thanks, Heidy.

Stetson?

MR. BERG: Yes. We have three main points here. The first one has already been talked about, the expand of broadband services to rural areas.

New Mexico is a rural and a frontier state. So that's been a pain point not necessarily for the access program since we have been connecting to health systems that generally have pretty good internet, but for telehealth, in

general, for the University of New Mexico.

The second one, which I think is probably the most important of the three at least concerning our program, is the focus on solutions which deliver educational opportunities to these rural providers, which allows them to treat more patients confidently and reduce transfers.

So there's plenty of apps or systems that might offer consults. But just because you consult with a provider in a rural area doesn't mean that they maybe feel more comfortable or more educated or have the tools or resources to be able to keep that patient.

Maybe the academic medical center thinks they can keep that patient that that rural provider maybe doesn't feel comfortable keeping that patient.

So we found that educating and offering free education to the facilities that have contracted with us really helped bump up that TPA administration, and the physicians feel comfortable making that decision and keeping the

patient, which didn't ultimately end in a consult and then a transfer because they just didn't feel like they should be keeping that patient.

And the other that I wanted to mention is originating site restrictions have been sort of detrimental to the optimization of health care delivery.

So just keeping those three in mind with the emphasis on providing the education that's provided with our service.

CHAIR BAILET: Thanks, Stetson.

Jeffrey?

MR. DAVIS: Well, thank you, Dr. Bailet, and thank you all for inviting me today, which is a great discussion and thanks again.

Just to kind of sum up what we've discussed today, I know we used the word "tool" a lot, but telehealth should be included in all APMs, in most APMs, as a tool, like we've discussed before, and it should be available to providers to help improve care and lower costs.

The ability to provide care to

patients from their own home can really reduce the need for unnecessary repeat visits and inpatient admissions, like we've discussed.

I think the key features to an APM, and successful APM, are a stable financing mechanism and aligned financial incentives so that everyone involved in the patient's care has the same financial incentives and are dedicated towards advancing clinical care and reducing overall costs.

There also has to be -- I discussed a little bit earlier there needs to be a shift in overall culture and perception of the emergency department.

We believe that emergency rooms are gatekeepers to the hospital and play a unique role in the health care system.

But currently when patients in the emergency room are admitted to the hospital or discharged, there's little follow-up from the emergency department.

There's just so much potential in

terms of value-based care to increase value in the system by getting emergency physicians engaged with the patients, helping to make sure that patients receive appropriate follow-up care and don't wind up back in the ED or admitted to the hospital.

And as we discussed, and I just want to say it again, telehealth is a key component to achieving that important goal.

So thank you so much again for inviting me today, and I look forward to future discussions on this important topic. Thanks.

CHAIR BAILET: Awesome. Thank you, Jeffrey.

Larry?

DR. KOSINSKI: Last but not least.

Telehealth is here to stay. It's always been needed, but restrictive rules inhibited its previous use.

The current emergency has opened the eyes of patients, providers, and payers to its failure.

It's time to define quality indicators for telehealth visits, quality structure for these visits, and real outcomes measures.

APMs have suffered from restrictive structures. They need to be innovatively expanded to promote participation in telehealth for all providers.

Although recent waivers and changes in CPT codes have been helpful, further changes are needed to create a platform of early detection of chronic disease.

mHealth promotes early patient engagement, which, if provided in a clinically proactive fashion, can decrease morbidity and cost. Let's not be penny-wise and dollar foolish. Thank you.

CHAIR BAILET: Thanks, Larry.

And, David, you're going to take us home and then any questions, any follow-up -- we just have a little bit more time -- any follow-up from my colleagues on PTAC, but go ahead, David.

DR. BASEL: Thank you, Chair.

So as Barbara and Heidy both alluded to, telemedicine is a tool. And certainly eLongTermCare we look at it that way as well, and we designed a program not to replace that local primary care relationship, but to envelope and support that primary care relationship.

And that's proven to be very effective through this public health emergency as kind of value-added services to be able to allow that to be more effective and efficient. And so it's been wonderful from that standpoint.

But also as we talked about that billing complexity of any one of these new programs that includes telehealth, it's probably the number one barrier that you're going to see.

And having to piecemeal out the billing for different aspects of that, having to figure out how to put it into an episodic fee-for-service type of structure even if they're care management fees, you know, you have to put up so many rules to keep overuse and ineffective use of those care management fees that that

becomes a barrier. The patient co-pays, that becomes a barrier.

And so by hooking it instead to a value-based contract, a physician-focused payment model, that allows you to take away so many of those barriers, and I think that's why it's so effective.

My day job, I'm medical director of multiple ACOs[16], both commercial and public, including a moderately large ENHANCED track MSSP[17] ACO.

So right now, in effect, I pay for this project in our own nursing homes out of our ACO-shared savings, and Medicare gets to come along for free for that, essentially.

And I can darn well promise you that if I didn't know that this place was a telehealth intervention, was saving the ACO money by reducing ED transfers, by reducing hospitalizations, by keeping patients healthier

16 Accountable Care Organization (ACO)

17 Medicare Shared Savings Program (MSSP)

longitudinally, I wouldn't be paying for it out of the ACO.

And that's what that value-based contract brings to that. And that's why you can, you know, loosen the rules that govern all this in that sort of a setting. And so we're very supportive of that.

And, as always, we really appreciate the opportunity to talk with the Committee, and this has been a wonderful experience from start to finish. So thank you.

CHAIR BAILET: Thanks, David. And this has been a great discussion. I really appreciate all of you.

Again, going back, you all submitted proposals. So all of your interactions with PTAC, your passion around care delivery and transforming health care, really appreciate your efforts all the way along.

And the fact that you were able to reach out and work with us to build out this panel and participate today, if we were in the

Great Hall, I would ask for a big round of applause; but, unfortunately, we're virtual.

So on behalf of everyone listening in and all of the PTAC and staff, we really appreciate your efforts today. A big thank you, all.

We are going to take a brief break. We'd like to reconvene at 8:45. But to give people a little more time, I'm wondering could we make that 8:50? I'm just going to ask staff to weigh in here and make sure.

When would you like people to reconvene?

MS. AMERSON: 11:45 Eastern.

CHAIR BAILET: Yeah. For some of us, that's 11:45. Like I said, 11:45. Some of us are not on the East Coast. So that's when it will be. 11:45 Eastern Time.

Thanks, everybody. It's been a great discussion.

(Whereupon, the above-entitled matter went off the record at 11:36 a.m. and resumed at

11:51 a.m.)

VICE CHAIR TERRELL: Welcome back to this PTAC public meeting. I'm Grace Terrell, Vice Chair of PTAC.

We will now continue with our discussions on telehealth, a theme we have found across various proposals.

Those of you who joined our earlier session had the opportunity to hear from many of those submitters.

*** Panel Discussion with Subject Matter Experts**

Now, we have convened a panel of experts in telehealth from a variety of organizations. You can find their full biographies on the meetings page of the ASPE PTAC website.

For this panel, we have several questions in the queue for each discussant to respond.

We will work through each question, and I will likely vary who is called upon first

to respond.

I'll ask that each panelist try their best to keep their responses to just a couple of minutes or so for each.

That way, members can have the opportunity to ask questions before we move on to the next question.

And for those who were part of the morning panel, you know that we were able to get through some, but not all, of our questions. So we'll try to be a little more efficient now with this session if we can be.

So first of all, I'm going to ask if each of you could introduce yourself, your organization, and the area of expertise or perspective you will be providing. Because this is virtual, I'm going to prompt each of you individually.

So Anne Tumlinson, please.

MS. TUMLINSON: Hi. Thank you very much.

My name is Anne Tumlinson. I am the

CEO and founder of a research firm based here in Washington, D.C., called ATI Advisory.

I am also the founder of a caregiving organization called Daughterhood.org, and my perspective that I'll be bringing today will be around the population that has a need for long-term care and experiences disabilities.

VICE CHAIR TERRELL: Thank you, Anne.

Sophia Tripoli.

MS. TRIPOLI: Hi, everybody. My name is Sophia Tripoli. I'm the Director of Healthcare Innovation at Families USA.

Families USA is a leading national nonpartisan voice for health care consumers that is dedicated to achieving high-quality affordable health care and improved health for all. So I will be bringing the perspective of the patient advocacy voice today.

VICE CHAIR TERRELL: Thank you, Sophia.

Dr. Lee Schwamm.

DR. SCHWAMM: Yes, hi. My name is Dr.

Lee Schwamm. I'm a professor of Neurology at Harvard Medical School, and I direct a center for telehealth at Mass General Hospital, as well as serving as the Vice President for Virtual Care and Digital Health at Mass General Brigham, which is our health system.

I'm speaking from the perspective of a provider. I'm a stroke neurologist, but I'm also a health services researcher focused on quality of care and outcomes in stroke.

So very excited to be here. Thank you.

VICE CHAIR TERRELL: Thank you, Dr. Schwamm.

Dr. Lewis Levy.

DR. LEVY: I'm Lew Levy. I'm the Chief Medical Officer for Teladoc Health, the leading telemedicine provider globally.

My own background is practicing general medicine in the Boston area for the past 32 years and teaching over at Harvard Medical School.

I was a full-time internist for 20 years and also taught in the residency program at the Brigham and Women's Hospital.

I've been in digital health for the past 12 years and will be bringing the perspective of technology to the conversation.

VICE CHAIR TERRELL: Thank you, Dr. Levy.

Dr. Chad Ellimoottil.

DR. ELLIMOOTTIL: Yeah. Thank you. It's a real pleasure to be here.

So I'm an Assistant Professor of Urology at the University of Michigan and have multiple perspectives on the subject matter of telehealth.

From a clinical perspective, I've been performing video consultations with my patients for many years since about 2016.

On the operational side, I'm the medical director of telehealth for my clinical department and have facilitated the growth of telehealth to about 40 providers and advanced

practice providers and physicians.

And then finally probably most relevant here on the research side, I'm the Director of the Telehealth Research Incubator at the Institute for Healthcare Policy and Innovation at the University of Michigan, where we're specifically studying the population level impact of telehealth on cost, quality, access, and the patient experience. Excited to be here today.

VICE CHAIR TERRELL: Thank you, sir.

Dr. Sanjeev Arora.

DR. ARORA: Thank you for this opportunity.

My name is Sanjeev Arora. I'm a gastroenterologist by profession, a professor at the University of New Mexico, and a founder and Director of the ECHO project.

The ECHO project is a way to marketize knowledge and bring best practice care to underserved people all over the world.

We are a hub-and-spoke network and

operate 1,000 networks in -- out of 41 countries with learners in 158 countries.

And I'm here to represent how the ECHO model of telehealth can be used to improve health care access for specialized care in the United States. Thank you.

VICE CHAIR TERRELL: Thank you.

And finally, Dr. Chuck Zonfa.

(Pause.)

CHAIR BAILET: I don't see him, Grace.

DR. ZONFA: I think I seem to be having technical difficulty with my video. So I'm trying to troubleshoot.

VICE CHAIR TERRELL: Okay. We can hear you, sir. At the bottom, is there a little button where it says where you can flash open to -- where you can show your video?

(Pause.)

VICE CHAIR TERRELL: Why don't you just go ahead and introduce yourself since we can hear you, and then I'll go ahead and get the question started.

DR. ZONFA: Okay. So I'm Chief Medical Officer at SummaCare. I'm an OB/GYN by trade.

The current practice that I do is overseeing the residents in the Women's Health Center here at Summa Health.

We are an integrative provider-owned health system that includes the hospital system, employed medical group, as well as an ACO and a health plan.

I'm happy to be here and participate, and I am representing the payer side of the house.

VICE CHAIR TERRELL: Well, thanks to all of you all and I am going to switch to your first names now so I won't mispronounce anything anymore, if I have, as we continue this.

So I'm going to start with Question 1. And so it is: For each of you, given your recent experiences from the public health crisis, can you comment on what you have observed and what might be the lessons learned broadly, from your perspective, be it patient, provider, policy,

payer, and so on?

So let's start with Sophia and then with Anne, who can provide for us the perspective of patients and individuals who may have experienced a change in access to services, as well as improvements, or even barriers, associated with recent care virtually.

So Sophia, if you can start and then Anne, and then I'm going to call on the rest.

MS. TRIPOLI: Thank you very much.

So there's no question, of course, that COVID-19 has had a catastrophic impact on American lives and lives around the globe.

So far, we've lost nearly 200,000 American lives in the United States with about six and one-half million cases of COVID-19. And of course, those numbers continue to increase every day.

COVID-19 has also generated the most severe economic downturn that our country has faced since the Great Depression, which has resulted in substantial job loss and historical

losses of health care coverage.

We've witnessed, at a terrible cost, how critical it is to have a national testing coordination strategy that is led by the federal government in order to save and protect the lives of our nation's families amidst a global pandemic and what it means if what happens when that leadership is lacking.

The result has been a patchwork approach for governors and mayors across the country who are forced to make difficult decisions about keeping their residents safe while reopening their economies without the necessary tools and resources needed to ensure that children can go back to school safely, that their parents can go back to work without fear of becoming infected with COVID-19 and possibly losing their jobs and their health insurance, and so that our frontline and essential workers are able to safely keep saving our nation -- serving our nation at a time when we need them most.

We've also seen how the COVID-19

pandemic has further unveiled the harsh realities of existing disparities in health and health care in the United States where Black, Latino, Native American, and immigrant communities have experienced significantly higher rates of infection and death.

We've seen the impact of structural injustices interacting with public policy such as variations in how counties are able to manage the outbreak and how the implementation of social distancing, testing, and economic support is reinforcing disparities.

For example, for many communities, physical distancing is a privilege that is much less available to low-income communities.

This includes low-income communities of color where Black and Latino Americans are overrepresented in service industry jobs that have less access to paid sick leave protections and where women of color are more likely to be considered essential workers.

Not only has this type of work exposed

workers to COVID-19, it has also increased the risk of exposure for their family members and neighbors as people of color are more likely to live in multi-unit dwellings or intergenerational households.

We've seen how important it is for the health care system to be accurately collecting data on race, ethnicity, and primary language, at a minimum, and how much work we still have to do to get this aspect of our health care system functioning properly.

This data is fundamental in being able to build a health care system that meets the needs of all the people it serves.

And in the context of Alternative Payment Models and value-based care, these data are critical for being able to build and implement equity payment incentives in health care.

We've also seen the need for improved data sharing and data interoperability across and within the health care system and with other

sectors that impact our health, like our public health agencies and social services, et cetera.

We've also seen that COVID-19 has sent shockwaves throughout the health care system where our health care providers and organizations have taken drastic and heroic actions to reorient workforces, modify facilities, prioritize critical services to provide effective and safe care for individuals with COVID-19, all while facing significant and continuous revenue shortfalls.

These revenue shortfalls are the result of large drops in utilization seen across the health care system as stay-at-home orders rippled across the country.

The drop in utilization has led entire sectors of our health care system being at risk for going out of business.

The most notable sectors, of course, being primary care, behavioral health, and dental care.

Primary care practices have seen a

decline of up to 50 percent in service volume, and pediatric practices have experienced 47 percent declines in service utilization.

At a time when our nation's families need access to primary care most, our primary care infrastructure is at risk of collapsing.

Telehealth services and capabilities of course have been expanded in scale in a matter of days or weeks, which has allowed families access to critical health care services under shelter-in-place orders because of the public health emergency.

And because of rules and regulations, the expansion and reimbursement of telehealth services has helped to generate some revenue in the short term helping to keep many health care providers' doors open, but it is very important to note that the way that health care providers are paid is actually what's driving the health care system's current financial crisis.

The predominant payment model in the United States, fee-for-service, offers no

backstop when utilization drops.

The limitations of pay-for-service economics were well understood before COVID-19, but now the impact of COVID-19 on our health care system has been a stark reminder that relying on volume to generate reimbursement and revenues of predominant payment law in our health care system is not only unsustainable, but is also driving many practices to be on the brink of going out of business, which is only -- which will only serve to reduce access to needed care for American families.

One of the key system level learnings we've seen is that providers and health systems who have participated in value-based payment have been more financially stable, particularly those in Advanced Alternative Payment Models who receive up-front ongoing payments not tied to fee-for-service.

Practices using Alternative Payment Models have been able to keep their doors open, keep seeing patients during the public health

emergency.

They've also been able to better meet the needs of patients -- the patients they are serving because their payments are built to support a wide variety of capabilities that are not currently supported under fee-for-service, such as care coordination staff, patient engagement tools, including 24/7 help lines, data analytic capabilities, and of course infrastructure needs to support telehealth, including remote monitoring and home-based care.

Providers utilizing value-based payment have been able to leverage these capabilities quickly to implement an effective pandemic response, while fee-for-service providers have had to rely on federal government to make rule and payment changes to move forward with these types of capabilities.

And finally, the rapid expansion of telehealth has been an essential tool to our families, children, and seniors to continue receiving access to health care services during

the pandemic.

However, patients still continue to face substantial barriers to accessing telehealth and virtual care services, including lacking access to internet and broadband services, lacking access to a cell phone at all, or a phone or computer with video capabilities, not having access to language interpreter services when using telehealth and virtual care services.

And then finally, and it's very important, that as we are -- and we're experiencing right now during the public health emergency that we need a really concrete, sophisticated way to ensure that telehealth services and virtual care services are meeting quality standards to ensure that families are receiving high-quality telehealth or virtual care services. Thank you.

VICE CHAIR TERRELL: Thank you, Sophia.

Anne.

MS. TUMLINSON: Thank you. Thanks for having me, and I really am just really

appreciative and -- of the acknowledgment and the opportunity to reflect the perspective of the population that has long-term care needs.

I'm just excited to see that incorporated more and more into these kinds of conversations.

So I should start quickly by just level-setting on a couple of things. I think sometimes when we hear the words "long-term care" AND we think nursing homes.

And especially during this public health emergency, the nursing home setting and assisted living settings have gotten a lot of attention because of the nature -- the congregate nature of that setting and the, you know, increased opportunity for infection and the higher infection risks associated with them.

But really, when we use the term "long-term care," what we're really talking about is a population that has a lot of difficulty performing really basic activities of daily living. So just, you know, trouble with bathing,

dressing, eating.

And in 75 percent of the somewhere around five to seven million people, older adults who have that level, who have a need for long-term service support, 75 percent of them or so, maybe a little bit more, are living in the community.

So they're living in single-family dwellings. They're not living in nursing homes or assisted living.

And so I just wanted to, you know, kind of level-set that this is, you know, one of the -- kind of the -- "the pandemic," and one of the huge challenges that we've had in serving that population -- and I should just say having a need for long-term services support -- is highly associated with really high rates of hospitalizations and ER use even when you hold constant the underlying chronic conditions that maybe have, you know, set the stage for those functional impairments to begin with.

So we know that issue is out there.

We have struggled mightily over many, many, many, many years to scale care models that serve this population effectively and actually reduce the use of a hospital setting.

And I want to say that's been true of population living in the community. It's also been true of population living in nursing homes and assisted living.

I mean, these folks have largely been stranded in the kind of -- I would say, in the -- like, they're sitting on a little island in the middle of our care delivery system trying to connect a lot of dots themselves.

And we have really, really failed, I would say, to scale the kinds of care models that we know work.

And I'm leading -- all of this is leading me to say that I think one of the most kind of encouraging things that we've seen as a result of the pandemic have been, at least in kind of the spots of our care delivery system where there have been, you know, really high-

functioning care models with lots of, you know, interdisciplinary team primary care-led, where they have been, you know, under some type of a risk-based payment model, they have been able to kind of really rapidly --

PARTICIPANT: I'm sorry, I'm having trouble hearing you.

MS. TUMLINSON: -- flip the switch. Sorry. My watch thought I was talking to it because I'm getting so animated, but they have been able to kind of flip the switch.

What we've seen is that they have been able to kind of very rapidly deploy -- Sophia mentioned this earlier, too -- the telehealth technologies that they need in order to serve the population.

And maybe just -- so, what's really exciting is that those care models, in the past, have been hard to scale, in part, because they require a lot of investment, and they require a lot of people, you know, to make them work.

They are interdisciplinary teams.

They have a lot of different people on them, you know. They're really focused on this population, you know.

Think of the PACE[18] model. Think of some of the enhanced primary care models that we don't hear about all the time, you know.

They require people to go to adult day care centers or to clinics so that you can get eyes on and address changes in condition quickly, have a hospitalization.

Now, all of a sudden we are seeing that maybe actually that kind of a care model can be delivered through virtual care much more than we would have ever imagined before.

And I've even had some case organization, you know, leaders say to me, oh, my gosh, maybe we can do this a lot more efficiently.

So it's not just about being effective -- of course it's helpful and being effective in reducing hospitalizations when you use it, but

18 Program of All-Inclusive Care for the Elderly (PACE)

now we're using it, and we're seeing that it's actually a much less expensive way to do very effectively maybe some of the things that we were doing before.

So I'm really excited about the potential for virtual care to kind of help us really scale up the care models that we know have really worked to help address the needs of this complex care population.

VICE CHAIR TERRELL: Thank you. And now for our other panels, I'm going to start with the provider perspective from Lee and then we're going to move on to Chad, Sanjeev, Lewis, and Chuck with what might have been the challenges, including those that may be associated with a particular population they serve, as well as the technical clinical practice or geographic limitations or barriers and so on.

So let's again focus this as much as we can on health and technology as it relates to how the pandemic has changed it and how it might impact our care models.

And I'm going to turn it over to you now, Lee.

DR. SCHWAMM: Great. Thank you.

Well, I endorse everything that's been said up until this moment. Let me just make a few high-level additional comments.

I think it's very important that as we build out these systems, we ensure that our data dashboards and the approaches we take to measuring quality and variation in adoption address social determinants of health, as was nicely outlined already.

One additional element I would add to that is concerns regarding privacy and location tracking, which makes some of our patients resistant to the idea of downloading specialized applications to conduct video and prefer to conduct them in browsers that don't track their location.

We have a challenge of balancing security with simplicity. The solutions need to be simple and easily accessible so patients can

quickly connect with providers, but they have to be secure so that they don't increase the risk of inadvertent privacy breaches or so they deter fraudulent meetings by malevolent actors.

We haven't seen a lot of that, we've heard a lot about it, but I think we need to make sure that we can create secure, but simple, solutions.

We, in our own health system, have not seen any of the concerned overutilization. We saw underutilization. We saw significant drops in our ambulatory volumes.

Even though our virtual care solutions restored 60 percent of the volume, we did not see a rampant adoption of telehealth for frivolous purposes, which I know has been a concern among the payers.

I think we also have to recognize patients don't just have limited digital literacy or English proficiency or access to technology. Some of our patients have cognitive, visual, or physical impairments.

Certainly as stroke neurologist, many of my patients would have trouble joining a video call alone.

So I agree with the prior comments, and those earlier in the day, about the need to think about the environment of care around the patient since we don't control that in a virtual environment if the patient is at home.

I want to just make two final points. One is to emphasize the importance of audio-only services.

It is really a health equity issue. I think we've all -- we've discussed that repeatedly.

If you pay at a lower rate or you don't pay, you're now going to build structural inequity into the payment system, and that is going to disenfranchise a lot of patients.

Particularly effective for us during the pandemic, we're treating patients with mental illness or substance abuse disorders.

Those individuals really benefitted

from the ability to reach out and connect audio-only, as well as keeping pediatric patients out of the doctor's office when appointments were not needed to be in person and, therefore, decreasing everyone's risk of exposure.

Lastly, I think we haven't talked yet about the trauma both to providers and patients of this social isolation and loneliness that the pandemic engendered.

And so virtual care solutions that we enacted in our system, and others as well, were designed to support team meetings, family interactions, medical interpreters at very important moments, goals of care conversations, decisions about life-sustaining treatment. They were extremely meaningful, quite hard to measure, and generally not billable.

So I think we have to understand that the avenues of care delivery that were created by virtual care sometimes were not just to replace an in-person visit, they were actually the only vehicle of care that was possible.

So I think we learned a lot, we saved a lot of PPE, we reduced a lot of exposure to providers on the inpatient setting, and we made sure that patients had access.

All those things are only possible with the caveats that were previously mentioned, right?

We need secure and predictable financing, and we need safe and secure and HIPAA-compliant platforms to do this in. Thank you.

VICE CHAIR TERRELL: Thank you, Lee.

I'm going to move to Chad now.

DR. ELLIMOOTTIL: Thanks a lot. Thanks for the opportunity again. And I -- a lot of what has been said, I completely agree with Sophia and with Lee.

I'll add my comments in. Some of it may overlap a bit, and I think kind of four big lessons that we've taken away from this experience; one is that there was a strong demand for patients and providers for telehealth, but it was not overwhelming.

And so I think resistance to change is still a big issue in health care, as we know. So just some data to back that up.

At our health system, and also using national Epic data, there was, as others have mentioned, about a 50 to 70 percent drop in outpatient/in-person care, and only about 20 percent of that was really salvaged through telehealth. So most people were still deferring care during this time period.

And as now we're looking into June, July, and August, and as health systems are becoming safer and allowing patients to come back in, most patients are still choosing in-person care.

And most providers -- a lot of providers are also kind of going back to the status quo of providing in-person care.

So you know, along with -- I'll second what Lee said that there was really no evidence that we've seen so far, or nationally I've seen in any reports, that there's been runaway use.

Actually, even in this time period where there's maximum flexibilities during this public health emergency, what we're seeing is in-person care plus telehealth care reaching about pre-COVID levels. So nothing above that right now, at least, and time will tell if that changes.

I think overall, we're going to probably expect about 20 percent of care delivery in the U.S. to be virtual.

I'll mention quickly my second point that the degree of telehealth use that's clinically appropriate was really dependent on the specialty.

So in our system when we saw -- we would look at psychiatry, mental health, mental illness visits, almost 100 percent were converted, and they -- they're actually staying converted to virtual care even now in August and September, while other specialties like orthopedics seem to be expanding more on the in-person side.

I'll mention briefly with some data about the access issues. I think it's been said a couple times, but in addition to the digital divide that's been mentioned a few times, I will mention that there is also this perception among patients where the quality of care through telehealth may not be equivalent to in-person care.

So we had a study by some colleagues that did a national poll of patients that were individuals that were age 50 to 80 in June, and two-thirds of them felt that telehealth care wasn't equivalent to in-person care. And about 45 percent of those felt the personal connection with their provider wasn't the same.

So that's really important and, you know, the digital divide obviously goes without saying is important.

With the audio-only and the other types of modalities, in our system, about 70 percent of the telehealth virtual care that was provided for patients that were over the age of

70 was done through audio.

So you know, there is the digital divide portion of it, but then there's also this preference portion of it, too, which is really important to consider.

And the final point that I'll make on this is that in-person interventions -- as we think about Alternative Payment Models and reviewing proposals, in-person interventions also need to be accessible to achieve necessary -- to achieve the outcomes that are desired through telehealth.

So I'll give you an example. It's good to have a technology that monitors chronic disease and sends a signal to a doctor when there's a red flag, but what does that provider do when they get that red flag?

If their answer is, you know, look at it, and if they're concerned about it, send the patient to the ER, then you're not going to see any improvements in population health as a result of that.

So the intervention -- so, is it the care team? Is it the home nebulizer, the home infusion?

If that's not part of the bundle of things that are covered, then you're going to kind of go down the path of least resistance, which is to have the patient bumped up to a higher acute setting whenever you get these signals.

VICE CHAIR TERRELL: Thank you.

Sanjeev?

DR. ARORA: Thank you. Thank you, again, for this opportunity.

I'm going to talk about very, very different use of telehealth than what you've heard so far. And I'm going to start with a little story to explain why this use is different.

One Friday afternoon 18 years ago, I walked into my clinic as a gastroenterologist and saw a 42-year-old woman sitting there with her two children.

And I asked her, you know, how I could help her. And she said she had Hepatitis C and wanted treatment. She had known about it for eight years.

And I asked her, why did she come now? And she said that she had called my nurse and had been told she was required to make a dozen trips to Albuquerque, 200 miles each way, and she didn't have the money for it, she didn't seek treatment, but now she was coming because she was having abdominal pain.

But it was too late because she now had advanced liver cancer and died five months later.

And I was asking myself, why did this mother of two children have to die? And she died because the right knowledge did not exist at the right place at the right time.

And New Mexico, at that time, had 28,000 patients with Hepatitis C and hundreds of patients were dying every year for lack of access for treatment, and that's why I started Project

ECHO.

And millions of patients in our country are unable to access specialty care on a timely basis.

And so we need to fundamentally reorient our health care system to enable us to quickly move new information and best practices from experts to providers at the front line caring for communities -- patients in their communities, and telehealth can play a very major role in this -- to make this happen.

The COVID-19 pandemic has only underscored this urgency, and that's where ECHO comes in.

ECHO, also called the technology-enabled collaborative learning and capacity-building model, is a highly scalable platform to exponentially amplify the implementation of medical best practices around the nation.

So what I have done was I had set up 21 new centers for treating Hepatitis C, and we share the treatment protocols, and once a week we

would discuss these cases in a de-identified way. Soon, they became experts, and the wait in my clinic fell to two weeks.

We knew we had an effective model, so we expanded it to training other academic medical centers around the United States.

And today, we have 250 hubs in the United States in 48 states training professionals in 20,000 organizations in the U.S. for 70 different disease areas, and there's a very strong demand for these models.

And what happens in ECHO is teams of -- - teams of experts at regional medical centers, called hubs, use one-to-many videoconferencing to engage with local health care providers and weekly ongoing knowledge sharing case-based learning and telementoring.

And hub and spokes learn from each other, and everyone's knowledge is improving, and we call it All Teach All Learn. We published in the New England Journal of Medicine using this model.

Rural providers can provide the same level of care as super-specialists, and now we have 275 peer-reviewed publications showing it's effective.

So for long, we believed that this can be used in a pandemic. But when COVID-19 came along, of course, for all across the world changed.

We are now partners, have now conducted almost 1,000 training sessions on ECHO, answering hundreds of questions, such as how to use personal protective equipment in the midst of a shortage, how much oxygen to deliver, what ventilator settings to use.

We have trained more than 200,000 public health professionals, doctors, and nurses in the U.S. since COVID-19.

And what this means for us going forward is that we need a new way so that the right knowledge exists to all the right providers.

When COVID-19 came along, our

providers did not know what to do with the patients. They didn't know how -- any of -- of how to intervene effectively.

And so I'm making a pitch today that in addition to the traditional telemedicine, which is extraordinarily useful and I endorse all the previous comments, we need a new model for technology-enabled collaborative learning and capacity-building so that all the clinicians in the United States have access to the latest knowledge and can provide the best care in their local communities, whether it be with telemedicine or directly.

And for this we need Alternative Payment Models, value-based care, or other innovative ways to make payment accessible for providers participating in ECHO projects and for academic medical centers that run ECHO projects. Thank you for your attention.

VICE CHAIR TERRELL: Thank you.

Lewis?

DR. LEVY: Thanks so much.

So I'd like to reflect a little bit about our experience to date and what we think are some of the more long-term implications.

In Q2, we exceeded 2.8 million visits globally. In the U.S. alone, we went from seeing about 10,000 patients a day to over 20,000 patients a day.

Interestingly, about 60 percent of the individuals that were seeking care had never sought telehealth in the past. We also saw a very accelerated growth in individuals 18 to 30, particularly amongst men.

Also would like to draw attention to the fact that we saw a great increase in terms of mental health visits, both individuals who had been diagnosed with a mental health condition, and this condition was exacerbated by COVID-19, and some of the isolation that other speakers have spoken to, as well as de novo mental health concerns.

So year over year, we're over 10 times where we were last year in terms of what we're

seeing in the mental health arena.

What does this all mean? We're seeing now that about 76 percent of consumers are quite interested in using virtual care, as compared to about 11 percent prior to COVID.

Interestingly, about a third of individuals would even consider leaving their current physician for a provider who offered virtual services.

About two-thirds are really seeing the need to have the virtual care integrated very closely with their in-person care.

What we're seeing from payers and employers is about 80 percent of large employers believe that virtual care will significantly impact the delivery of health care in the future, and that implementing more virtual care services and solutions is the number one priority for large employer health initiatives.

For health care providers, as has already been pointed out, 50 to 175 percent increase, depending upon where you're looking.

Sixty-four percent of the providers are now more comfortable using telehealth than in the past.

I would also like to draw attention to the recently released findings from the NCQA[19] Taskforce on Telehealth Policy, which was released this week.

This was an effort where the NCQA brought together 23 stakeholders, including Teladoc Health, along with CMS, Kaiser Permanente, and a number of other organizations.

And they basically felt very strongly that looking at this that they felt that many of the concerns about telehealth, they studied what's been going on over the past six months and found, you know, very interestingly that with the diminution in terms of wait times and issues around travel, that there was actually improved quality outcomes through telehealth and much greater adherence to care plans due to telehealth.

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As Lee has already highlighted, there was never evidence of increased utilization and increased volume of care.

They felt that existing policies that are defining requirements around site of care should be eliminated.

They also felt that there should be consideration given to universal provider licensing.

So getting rid of this notion of you only have a Massachusetts license, so, therefore, you can't take care of somebody in Vermont, should be reevaluated.

And also, that many of the relaxations around HIPAA should be put back into place now in a post-COVID era.

Certainly wholly endorse the issues that have been raised already in terms of addressing social determinants of health as we have been very strong advocates that telehealth should always embrace an audio-only option.

In terms of what are we doing in terms

of expanding access, we've always endorsed audio-only. We've always endorsed, you know, having language lines and interpreters.

And in terms of the elderly population, we've had a caretaker program where it basically can bring on, you know, the family member to sort of help through the encounter with the elderly individual.

We are on track to be doing over 10 million visits this year, and we think that critical to our success, both today and going forward, is always to have a careful attention towards the quality of care that's delivered.

So we've been working very closely with the NCQA, the NQF[20] and a number of -- URAC and a number of other organizations to really ensure that as we are delivering care, we're constantly measuring the quality of care to ensure that with scale come improvements in the overall quality of care.

So thank you so much, Anne, and happy

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to address any questions as they may arise.

VICE CHAIR TERRELL: Thank you.

Well, I'm going to finish this part with Chuck and then what we will do after you've had a chance to speak, Chuck, is I'm going to give the panelists time to ask some questions.

One of the things that we are not going to be able to do is go through all five questions in this format.

But as I'm listening to you all, you're very thoughtfully answering a lot of the other questions.

So I'm going to mix it up after you've had a chance to talk, Chuck. We'll ask our commissioners if they've got questions.

And then I'm going to ask for some rapid response answers on certain things from you if they're not answered with the -- from the things that the commissioners ask for.

And then we're going to end with a final 10-minute question where you're really going to all give us your deepest insights as to

how we're going to get everything better.

So Chuck, bat cleanup on this for us. It's good to see you joined us on the video, and then we'll go to the next part.

DR. ZONFA: Thank you, Grace.

I think that I have effectively demonstrated that technology is not always easy or intuitive. So that was my goal, and I'm glad I achieved it.

From the standpoint of what are the lessons learned, I think that there is a couple of important ones.

One is, telehealth is a valuable tool. And I think we've demonstrated that over the past few months.

And that I think it was said, in the earlier panel, that telehealth is here to stay, and I think we're still struggling with where exactly it fits.

One of the things that strikes me in the conversations we've had earlier, and even the one happening now, is that we are starting to see

a cultural shift.

And I don't think we are as far down the continuum of a complete cultural change yet, but we have done two things.

One, is we've changed the culture of the providers, at least I'll speak for my own region here in northeast Ohio, in that there was probably very slow adoption of telehealth services before the public health emergency.

And we demonstrated that the -- that effective care can be delivered through a nontraditional face-to-face visit. And I think our providers rapidly adopted that technique and ran with it.

In fact, I think that we saw at one point in time in the height of the pandemic, we probably had an adoption rate, especially when office visits started to drop dramatically, of about 60-some percent.

We have now normalized probably down to about 20 percent of visits within our own medical group.

So I think that this cultural shift is changing on two fronts. One with the providers, and a second with the patients.

So in the fee-for-service world, you know, we have traditionally had to -- the only reimbursement that providers could get was through a face-to-face visit typically.

And what the pandemic has demonstrated is, from the patient perspective, I don't necessarily need to come into the office. I don't need to take that four hours for a 15-minute office visit. I can get the information that I need and sometimes get the questions answered and the care I deserve in a nontraditional visit.

And I think that we have set that expectation in our own population quite differently.

I wanted to highlight a couple of other things. One is, one of the main lessons we learned through the public health emergency is the value of communication.

Not communication necessarily just between provider and patient, but communication from the payer perspective with our provider network and with our membership.

So one of the early mistakes we made is we were not actively communicating with those two groups of individuals, and we received a flurry of calls and questions from both our membership, as well as our provider network, on things like what can I do during the public health emergency to offer care, how can I get reimbursed for that type of care, and how are you going to change your payment models to help to offset some of the decreases I'm seeing in a face-to-face visit.

And I think we followed the CMS guidance on: one, showing the value of an audio-only visit and providing reimbursement for that at the same level as a face-to-face, but we developed a task force that -- it was the COVID-19 Task Force that met daily, which involved not just the medical management team from our health

plan, but also payment guidelines, our communications, our marketing team.

One of the things that it forced us to do was to make sure that the information on our website for both providers and patients was accurate and consistent and up to date.

So we met daily and made sure that we were using multiple modalities to communicate with both our membership and our providers.

And I think that made a world of difference because we saw that flurry of calls start to decrease dramatically quite rapidly.

The other thing that we've done in our region is we've embraced value-based models, especially with our own ACO, and have looked for ways to pay for care through alternative models, not just a fee-for-service, face-to-face visit.

I think there's a tremendous amount of work that payers can do in that space beyond what we're already doing so that the value of a telehealth visit or using telemedicine is realized.

But there are two caveats to that, and I think this was mentioned also in the earlier panel.

One, is we've seen a lot of -- we have not seen any abuse of telehealth visits like most others have echoed on the panel, but the one thing that we see is variability in what a telehealth visit means.

So whether it's audio-only or video-only, it would be nice to see us progress to something that is this is the standardization for a telehealth visit, this is the components that you need, there may be even various, different levels of what a telehealth visit pays, and also what are the triggers needed for a face-to-face.

And I think that's what we're missing, from a quality standpoint, and that is what concerns me a little bit, as both a provider and on the payer network side, is that we haven't quite established.

And I think somebody mentioned earlier what those guidelines are for a telehealth visit

and what is an effective telehealth visit from a quality standpoint.

So I think we are on this trajectory, but I think there's a lot of work to do in ensuring quality.

And the other more -- most important thing is, as a payer, what we've done is we've engaged other vendors, organizations, to help surround the care the patients receive, whether that's our agreement with Teladoc or even we have a telemonitoring program for chronic conditions.

But what the pandemic has shown is that we need to drive those initiatives through the care delivery network to ensure that: one, whatever happens in a telehealth visit is easily accessible to anyone that touches that patient, and; two, to make sure that all those different modalities are coordinated so that there's an awareness for the provider who is currently interacting with that member or patient to understand that they are receiving these other modalities and to make sure that they are

enhancing that care, rather than creating more disjointed care and inhibiting a comprehensive holistic approach.

VICE CHAIR TERRELL: Well, thanks to all of you for your very insightful and very thoughtful responses to the first question, but you've now eaten up all the time for a lot of in-depth on the others.

I'm going to give my colleagues a chance to ask questions and I think I saw that -- Jennifer, I believe your hand has been up since the last one.

So I'm actually going to -- I think -- I don't know if that's real or not. I'm going to start with Jay Feldstein. And then, Jennifer, if that's real, just let me know.

DR. FELDSTEIN: Thank you, Grace.

My question for everybody, but probably more directed towards Lew, is how do we make sure we're not creating another giant health care silo?

Because health care is famous for

developing silos and especially among freestanding telehealth companies.

How do we make sure that we get it integrated, and to what Chuck was referencing earlier, across the entire health care delivery system?

DR. LEVY: Thanks, Jay.

So you know, having -- you know, someone who's spent the past 32 years in -- practicing in Boston and having actually admitting privileges at the -- both the Brigham and Women's Hospital, as well as the Beth Israel Deaconess Medical Center, you know, just amazing to think that here are two institutions that literally are sitting across the street from each other and do not share a common electronic medical record.

So an individual could literally be in the Brigham emergency room one night and be presenting the next day with the same complaint and not having easy transmission of information.

So that problem with interoperability,

which folks have been talking about for over the past 20 years in terms of building out kind of this information superhighway, is still an extremely relevant issue as we get into the age of virtual care.

So I think that interoperability so that any provider, whether it be in a brick-and-mortar setting or be in a virtual setting, has total access to the information.

And that the information is not siloed into individual hospitals, health systems, but is kind of more universally shared.

So we're working with all of our partners. We have a significant -- particularly with our recent acquisition of InTouch Health, a very significant investment in trying to enable physicians to take care of their own patients through our technology, and we feel as though this interoperability is key.

We are also in the year ahead going to be launching, based upon a very successful pilot that we were able to do this year, our own

virtual primary care offering.

So the actual physician that would be that coach, if you will, that real head of the team, will be the patient's virtual primary care doctor and will be able to obviously communicate effectively with the other members of the health care team.

Also with our coming together with Livongo, we basically feel as though these digital tools can now be leveraged to not only provide that information back and forth between patient and digital tool but also digital tool to provider.

So we really think that that's also going to be foundational in terms of the information sharing.

Will this require new economic models? Yes. Will this require more attention towards value-based care? Absolutely.

We're really excited to go forward, but I think I could not agree with you more. What we do not want to do is to create a whole

elephant that is totally in its own silo and not interdigitating with the rest of health care delivery.

DR. FELDSTEIN: Thanks.

DR. LEVY: Sure.

VICE CHAIR TERRELL: Thank you. Josh, you have a question next?

DR. LIAO: I do. Thank you, Grace, and thank you, everybody, for your comments.

My actual question is on the other side of that, which is to say one of the things I've appreciated from what everybody has shared is the variation not only in telehealth, but how it's applied in your local setting.

So the difference between audio-only, video, audio, for instance, the idea of what really is telehealth, the notion of it really depends based on clinical area, maybe specialty, and it may differ by disease state. We've heard different things.

And so the silo is one thing, but what I'm struck by is kind of the other side of, you

know, 1,000 flowers blooming, everybody doing what they're doing here and looking for some alignment behind that.

So maybe this is a rapid-fire question, but I'm curious what is the first bite of the proverbial apple?

How do we, as a country or region or community, avoid silos and work together, but what is that first bite because there can be potential paralysis, right, saying, well, there's so many dimensions of this thing that -- where do we start?

I'm curious about people's thoughts on that.

DR. SCHWAMM: Well, this is Lee Schwamm. I'm happy to just take a -- make a quick answer to that.

I think that we need to understand how to deliver care in our integrated delivery networks in a way that incorporates virtual care, telehealth services very effectively and efficiently.

So I think that is an ideal environment in which to ensure that fragmentation of care is not a barrier and is not an inadvertent consequence.

But just like that, you know, we have FedEx and we have the U.S. Postal Service, there are important roles for private players like Teladoc and others to fill in the gaps and to create care delivery models for patients who don't fall into integrated delivery care networks.

So I think that it's really important that we think about partnerships, both demonstration projects with CMS, value-based care and Alternative Payment Model contracts that are very attractive for health systems.

Rather than putting a lot of up-front investment and the -- a possibility of shared savings at risk, we need to really create lower barriers to entry so that health systems embrace this.

And if they have predictability and,

you know, a five-year roadmap knowing that there is reimbursement in place, they can afford to make the investments to actually create lower cost and lower cost settings.

If it's just a one-year, two-year demonstration, we don't know what's going to happen with the PHE expiring, very hard for systems to invest in the kind of overhaul that we need.

MS. TUMLINSON: Can I just add something?

VICE CHAIR TERRELL: Go ahead.

MS. TUMLINSON: I just wanted to -- I just think what Lee said is so exactly right and so important, which is just especially when I think about the populations that I deal with, the really complex care needs and lots and lots of interacting with the medical care systems or interlocking with the long-term systems.

And, you know, I think it's a mistake to say, gosh, you know what? We're going to assume that an investment in telehealth pays off

under the current way in which we've structured APMs that, you know, we're going to -- or, you know, like, everything can be solved if we just put all of, you know, if we just kind of hand the rest over to these entities and then share in savings with them.

We have to make it really attractive. Like, I think we have erred a little bit on too cautious of a side in terms of just ensuring the investments in the kinds of things that we know work.

And so you know, making it more attractive, thinking about how maybe just to kind of, like, we can, you know, turn the dial back a little bit in the other direction so that it is absolutely a good investment for, you know, about, you know, a large player in a market, a large physician practice not just to -- you know, not just to sort of embrace virtual care, but to also kind of build the care delivery infrastructure within their organization that can make sure that it's being used in a way that is,

you know, ultimately improving care for everybody.

DR. ARORA: Grace, is there a way I could take that a little bit?

VICE CHAIR TERRELL: Yes. Please.

DR. ARORA: This is Sanjeev.

So one of the -- you know, one of the challenges, of course, is that as long as the reimbursement is purely fee-for-service, integration of these silos becomes very complex.

So I think that really moving to Alternative Payment Models or value-based care or what you call accountable care where the system is actually responsible for the entire care delivery of the patient and responsible for quality of care, responsible for patient satisfaction, responsible for the community health, then what happens is that integration becomes a natural consequence.

Then, it is against me if my electronic medical record doesn't talk to the neighboring hospital, but right now the payment

systems, as designed, are absolutely antagonistic to this idea of breaking down silos. In fact, they are designed to create silos.

And so I think a much more fundamental change in reimbursement will be required to achieve some of the really great objectives that you outlined.

VICE CHAIR TERRELL: Sophia, did I forget you?

MS. TRIPOLI: Sorry, Grace.

VICE CHAIR TERRELL: Yeah. Sophia, you wanted -- your hand was up and then Jen had a question. So I wanted to give Sophia a chance to speak next and then Lauran or any of the others.

And then I'm going to do something different after Jenn's had a question or the others; is that okay?

MS. TRIPOLI: Thank you, Grace.

I just -- very quickly I completely agree with the comments just made. And I would say part of making that shift -- I mean, by design shifting -- like, Alternative Payment

Models shift the economic incentives, right, so that payment to providers is not based on widgets or transactions, but it's actually based on clinical judgment and improving patient health. And I think part of doing that is really making fee-for-service less appealing.

And there are probably some very unpopular ways to go about doing that such as depressing fee-for-service payments, but I think to really be able to integrate telehealth into health care payment and delivery -- and there's been a lot of conversation about, you know, telehealth being a tool and its own separate modality, which I think is really at the heart of the question that was being asked. It's really about integrating into existing APMs, Alternative Payment Models, existing value-based arrangements that are already making fee-for-service less appealing and then allow[] the provider to actually provide whatever the set of services are that they need to provide to meet their patient needs. Therefore, reducing silos and reducing

the fragmentation of care, et cetera.

VICE CHAIR TERRELL: Thank you.

Lauran, did I miss you? Were you wanting to add to this conversation before we went to Jennifer? I don't want to disrupt if it's about the same string here.

MS. HARDIN: Thank you, Grace.

I was going to bring up the concept of really centralizing coordination in the community, which came up in the comments. Thank you.

VICE CHAIR TERRELL: Thank you.

DR. LEVY: Grace, can I just make one just final quick comment about that, which is I think value-based care or accountable care is a natural home for virtual care and telehealth. No question.

But I think it would be -- we would leave with the wrong impression if we said it does not have a role in the fee-for-service side.

So many of our super-specialists, subspecialists, who practice in academic medical

centers, are inaccessible to many patients.

A lot of networks now are carving out and creating restrictions around who can access care.

And so you know, I think those patients in New Mexico that Sanjeev was talking about, if there's a hepatitis expert in Connecticut, they ought to be able to access that patient.

And many fee-for-service arrangements still exist between ACOs when they buy out components of care that they can't offer.

So I don't think we need a new payment mechanism. We already have a payment mechanism in the RVU[21]-based system that recognizes care complexity or time-based billing, and we have modifiers to reflect that the care was delivered over telemedicine.

So I just want to make sure fee-for-service doesn't get portrayed as a place that telehealth is not valuable.

21 Relative Value Unit (RVU).

VICE CHAIR TERRELL: Okay. Jen, I'm going to let you ask your questions. Chuck, I see that you've also got your hand up.

After that, I'm going to see if we can stop it because I think -- here's what I want the rest of you to do and be thinking of while we're finishing with this.

I'm going to ask each of our expert panelists to have two sentences for which if they were to be able to say directly to Secretary of Health and Human Services, what ought they to do going forward with respect to telehealth and Alternative Payment Models.

If you could write it down and say it, that's going to be the last thing that we get done here because I think that will help us with all the rest of the stuff you're doing.

In the meantime, though, you've got to think about what Jennifer is getting to ready to ask and then, Chuck, what you want to say.

I can tell you're all multi-taskers. So I think we'll be able to do this.

Jen, go ahead.

DR. WILER: Yes. Thanks for the opportunity to ask a question and hopefully this question will prompt a response also to the question Grace asked.

So I'm struck by -- thank you all for being here. It's been a phenomenal conversation. What I'm struck by is the perverse incentives of our current system that is hybrid, right, this range of fee-for-service to some in-play Alternative Payment Models and the points that were brought up around some of our most fragile communities being the ones that end up having this perverse incentive to move from a virtual visit into the clinic where, depending on the payment model, it may actually be a more expensive visit depending on the arrangement.

So if it's for a Medicare population, as was described, it might be familiarity and comfortability with the technology or other indigent populations, including patients with Medicaid.

And, as you all know, there is literature actually about this. So it is not without controversy, but what I will say is maybe reduced access to technology.

So at the end of the day, our federal payers, more than anyone, should be interested in this because of that perverse incentive about site of service of care.

So my question is -- and, Chad, you brought this up around trends that you're seeing. I'm curious about our current payment model and its perverse incentives and how that's driving all of the data around demand that you and others have described, Lee and Lewis, and how do we reconcile the data around need, demand, utilization, with what's currently existing because of these incentives. Thank you.

VICE CHAIR TERRELL: Okay. So I'm going to let you all answer that. You called out a couple of the panelists, so we might start there.

But before we do, Chuck, do you want

to save your comments for the end or do you want to contribute right here, because your hand was up?

DR. ZONFA: I'll contribute right here very quickly.

I think that -- so, our region is still heavily fee-for-service, but we've enhanced that with value-based agreements with our provider network.

And I think that if we follow the old model of value-based agreement, here's a care coordination fee to do whatever you want with, I don't think we're going to drive anything forward that's meaningful.

And to the point that others have made, I think what we're going to need to do is change the payment model and provide some type of funding for the network or for providers to deliver telehealth services, but we can't do that without having a very concrete conversation on here's the services that we bought, whether that be Teladoc or home telemonitoring from another

organization, and we should have a conversation on here's what we, as the payer, are willing to pay for and here are very concrete expectations for what we expect from you in the care delivery system from the standpoint of providing telehealth services.

Here's what we provide, here's what you provide, and try to figure out how to get those together without -- as everybody has alluded to -- not making another silo of we bought this service way over here and completely disjointed from the care delivery system happening in the office.

VICE CHAIR TERRELL: Thank you.

Jen, I believe you called specifically out to Chad and some others.

Chad, do you have a comment here?

DR. ELLIMOOTTIL: Yes. Absolutely, Jen. That was an outstanding question, and I think that I can certainly speak to it.

I think that one thing that is really important is that I think the -- and this was

brought up in the panel before -- I think the three things that are really important for policymaking related to telehealth is -- the top three things are the impact on disparities, the impact on cost, and then the association of telehealth with outcomes, clinical outcomes. So those are the top three things.

And so speaking to the disparities angle, which is what you asked about, I think that knowing -- well, first thing -- first, was when we look at how, during this pandemic, different populations used telehealth.

We know that there is a digital divide, but yet when we look at -- and we have access to state insurance data -- and when we looked across the state of Michigan, we see that every one of those populations, like rural versus non-rural, low-income versus higher income, you know, minority groups and so forth, what we see is that all of those groups did increase the use of telehealth during this time period, but there was a delta between those groups of interest and

their counterparts.

So there was a delta, but there wasn't any population, even populations over 80, that was significantly left behind with this adoption of telehealth.

So that's an important point, is that all the populations are increasing the use; it's just at a different rate.

And so I think having this data up front, having -- seeing what happened during the pandemic actually offers policymakers a lot of insight into what will happen over the next 12 months, next 24 months, if there's no policies that are in place or interventions that are in place.

And so -- and that could be at the federal level or that could be at the local level.

So knowing that older populations have challenges with using the technology, investing at the local level, investing in community centers, buyback programs for smartphones,

subsidizing connected devices, everyone knows about expanding -- the programs that are out there for expanding broadband, but then those are all patient-level interventions.

But then also at the provider level, there's providers in those communities as well that are not adopting telehealth as much as their counterparts.

So you know, investing and subsidizing telehealth purchases or subscriptions to those providers in that area is going to be very important, too.

So those are just kind of some quick ways -- I mean, it's obviously a big topic, but the fact that everyone is talking about it is really important, and that's really the first step towards mitigating that digital divide.

VICE CHAIR TERRELL: Thank you, Chad.

So I -- just looking at the time here, I know that we've got several people from the public who are wanting to speak.

I'm going to give you all just that

one more minute now to think about the one to two sentences only that you're going to advise us as we're thinking about how we might advise the Secretary.

While you're thinking for a minute, let me give you my personal experience with telehealth because I think it might be insightful.

Typically, if we were actually deliberating on a proposal, we would all have to declare any conflicts of interest or anything else to disclose.

It struck me while I was listening to this, that I ought to disclose I used to be a provider for Teladoc, have done about 5,000 visits in 2019 in about a 10-month period of time before COVID and before the waiver, and there were several things that I learned from that experience.

One of them is that it actually met the need of a lot of people -- this was typically in commercial insurance or those without

insurance, not Medicare or Medicaid -- who needed health care services that did not need to be provided in person, but yet they had no access.

And so much of it was -- it was a surprising amount of dental care need. Many minor dermatologic problems. Lots of mental health.

You flip that to the year 2020, and I am the CEO of a company that has 650 assisted living facilities and skilled nursing facilities in five states that we had to provide to primary care, mental health services, and some other services overnight, like everybody else, to the most vulnerable and isolated population in the country during the epidemic.

And that was a completely different telehealth experience to a completely different population.

So I, for one, am a believer that it is a solution for many things. And I've had the experience both pre- and post-COVID.

So I believe that gave you all time to

think a little bit about your answers while I went on my soliloquy.

And what I'm now going to do, and I will be starting with you, Sanjeev, is just give you a -- just a moment, give me one, two, or three sentences on what do you think with respect to Alternative Payment Models and telehealth that PTAC needs to advise the Secretary.

DR. ARORA: Thank you, Grace.

I think that what I'd like to say that is in addition to direct telemedicine models which are extraordinarily useful in overcoming geographic barriers to care and taking care where patients need it, we need -- we have another very major problem confronting the health system, and that is the exponential growth of new knowledge and constant change that is occurring in this knowledge.

So the primary care provider or any physician living in a town in the United States doesn't have the ability to keep up with that information.

So we have a great opportunity to use telehealth or technology-enabled collaborative learning models where people can learn from each other, where we can build the latest knowledge to the last mile of health care and then use telehealth not just as a revenue-enhancing model, but use it as a way to provide the right care at the right place at the right time.

And sometimes it will be telehealth, sometimes it will be direct care, but for any kind of care to occur effectively, what you need is the right knowledge at the right place at the right time.

Without that, no technology can solve the patient's need adequately. And for that, we need new payment models. Thank you.

VICE CHAIR TERRELL: Thank you.

Anne.

MS. TUMLINSON: I think I'll just say what he just said.

(Laughter.)

MS. TUMLINSON: This is transformative,

without question it's very exciting, but it does require a lot of flexibility.

New or, like, really kind of much more, like, greater degree of courage on the part of policymakers in allowing for more flexibility and investment in both paper service and Alternative Payment Models.

And we have to -- the long-term care population is going to get stranded if we don't do a better job of promoting and investing in the APMs that actually support the primary care, multidisciplinary teams that serve this population.

Like, that -- we can't -- like, telehealth isn't the solve. It is the thing that will help the solve work in scale.

And so you know, like, let's -- now we know we have this tool. Let's really double down on those models that we know work and the payment systems that support them.

VICE CHAIR TERRELL: Thank you very much.

Chuck.

DR. ZONFA: So mine's going to sound pretty similar, too. I would say support models of care that provide the five guidelines for appropriate use and ensuring quality.

And, most importantly, and you may have heard this before in the last comment, but support a payment model that allows flexibility.

We don't want a one-size-fits-all to be blanketed across the entire population of the United States.

I think that different geographies have different needs, and we have to have flexibility built in. I'll end there.

VICE CHAIR TERRELL: Thank you.

Lewis.

DR. LEVY: Well, I think it all boils down to you never let a serious crisis go to waste.

And I truly believe that right now in terms of two specific recommendations, they would really be along the lines of parity with regards

to reimbursement between in-person care and virtual care, and also supporting infrastructure that really facilitates integration of virtual care with in-person care to address the issues raised before around interoperability.

VICE CHAIR TERRELL: Thank you.

Lee.

DR. SCHWAMM: Simply put, remove the barriers to virtual care so they are treated similar to in-person care. Expanding the access for either in-person, virtual, or a mixture of the two.

It's just really simple. Just make it simple and make sure we don't build a system so arcane and complex and byzantine that patients are getting surprise bills or lack of access, and providers and facilities are at constant risk of noncompliance when they're simply trying to do the right thing.

Really simply actually. Just treat it like any other kind of care.

VICE CHAIR TERRELL: Wonderful.

Chad.

DR. ELLIMOOTTIL: Thanks. So Lee said it better than I was probably going to, but I'll -- these are my -- my two points is -- one, is that simplicity is extremely important.

So fragmented coverage and over-regulation is why less than one percent of Medicare patients have never used telehealth, even though telehealth was actually covered and paid for for the last 20 years.

And it's because of these, you know, a patient has to go to a certain location, has to be in a certain area, the path of least resistance has been not to use it. So simplicity is going to be extremely important for policymaking.

And then the second important point is that as you think about the sort of paying for telehealth coverages, the financial gain from using telehealth must outweigh the costs of using it and whether -- cost of implementing it, whether that's in a fee-for-service environment

or whether that's in an Alternative Payment Model.

In order to think about that, you have to think about the entire episode of care. So it's not just reimbursing for remote monitoring, but also the interventions that are needed to help get that desired outcome, whether it's community paramedics or home infusions, whatever it may be. Thanks.

VICE CHAIR TERRELL: Thank you.

And, Sophia, you started this with your marvelous thoughtful approach as a patient advocate and thinking about disability, so I'm going to let you finish with your advice to the Secretary.

MS. TRIPOLI: Sure. Thank you so much and thank you for the opportunity for Families to be here today.

Just three points. I think the first, as we've heard from others, is unleash the data. It needs to flow. It needs to be interoperable.

The second is integrate telehealth

into existing Alternative Payment Models. We're already shifting the economic incentives to be prospective, et cetera. There are already models that are doing this. CPC+[22], Track 2, Primary Care First.

And then third, when we're building -- modifying existing APMs or building new ones, get -- leverage them to reduce the digital divide.

Get direct support professionals, including community health workers, patient care navigators, social workers, into the care teams so they can work directly with patients and help provide illiteracy skills, et cetera.

And then, you know, figure out how to leverage APMs to get technology into patients' hands.

When providers are not relying on fee-for-service and are in an APM, the shift to economics allows them to get a tablet, get a computer into their patient's hands so that they can actually overcome some of that digital

22 Comprehensive Primary Care Plus (CPC+)

divide. Thank you very much.

VICE CHAIR TERRELL: Okay. You've all been wonderful, and I want to thank all of our panelists for their keen insight.

We are grateful that you've shared your time, experience, and ideas with the community, with our audience here today.

As Jeff said this morning to our previous panel, if -- this would be the point in the Great Hall that we would ask for applause, but I'm just going to give you snaps right now. So this is awesome.

So at this point, I'm going to turn things back over to Jeff as we're going to move into our public comment period. Thank you all very much.

CHAIR BAILET: Thanks, Grace, and I echo your appreciation for the panelists. That was great discussion.

I look forward to digesting it, and hopefully we'll be incorporating that feedback into our evaluations of upcoming proposals as we

move forward. So really appreciate your time today and expertise. That was awesome.

*** Public Comments**

We're going to move into the public comment period, as Grace said. We have, I think, five folks who are signed up.

The rules of engagement here are each commenter will be limited to two minutes, if we could.

The folks on the staff will unmute each individual after I call them and then feel free to go ahead and start commenting.

So first up is Harold Miller, who is with the Center for Healthcare Quality and Payment Reform.

MR. MILLER: Thanks, Jeff. I appreciate the opportunity to be here.

Can you all hear me?

CHAIR BAILET: Yes.

MR. MILLER: It's very clear from your discussion today that in a large number of circumstances, telehealth is a highly beneficial

service for patients, and in a lot of circumstances, it's an essential service.

It's also quite clear that telehealth can't be delivered if not paid for. And until six months ago, most telehealth services were not paid for.

Today, Medicare is 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 providers to diagnose or treat a patient's health problem in a way that gives them 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 will do just that, provide flexible, patient-centered payments tied to outcomes, not to specific places.

PTAC has recommended a dozen of these models over the past three years. Unfortunately, CMS has not implemented a single one of these models.

If CMS had implemented them, tens of thousands of patients could have been benefitting from telehealth services long before the pandemic.

CMS has said that it would take them years to implement PTAC's recommendations and that they don't have the bandwidth to do that.

Miraculously, though, CMS found the bandwidth this spring to issue over 100 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 biggest barrier, not physician or patient

resistance.

It shouldn't require a pandemic in order to get the changes in payment that will help patients get better care.

Congress clearly needs to change the law so that CMS is required to implement more physician-focused payment models more quickly.

And I urge PTAC to recommend that to Congress that they change the law in the report you issue after today's meeting.

CHAIR BAILET: Thank you, Harold.

We're going to go with Gretchen Alkema with the SCAN Foundation. Thank you.

VICE CHAIR TERRELL: Yes. Gretchen dropped off. They're trying to reach her. If you could go to the next one, please.

CHAIR BAILET: Okay. We have Keisha Houston, a researcher. Keisha.

MS. HOUSTON: Yeah. I listened to everyone, and it's a joy to be here. This is not speculating, but it's kind of an inspiration to see how these things are addressed about what we

need to do and how more proposals need to go out as far as asking to what needs to be accommodated. Especially, one gentleman had brought up about payment issues.

Now, a reduction of collaborating a lot of issues, but reducing payments because of certain places not paying, you know, becomes an issue with us especially when it comes to, you know, we have to, you know, ask and try to find certain areas that will help, and it's not easy. So we just do what we have to do, you know.

And some of these questions is an inspiration about, you know, about trying to collaborate and trying to be more, you know, into, you know, into what things need to be done.

So yeah, I'm new at this, but, you know, the question that has been issued as far as payments and what can be paid, what cannot be paid, say, for instance, on dialysis or other issues that have been, you know, brought up, you know, it's just trying to find, you know, who will, you know, or who can we ask for, you know,

this mission to happen.

But, you know, as far as this concern, you know, it is going to be taken care of, you know, and just an inspiration as far as everyone issuing -- bringing up what needs to be done and, you know.

And so we're going to do more better than what we do then. Thank you.

CHAIR BAILET: Thank you.

We have Kelli Garber from the MUSC Center for Telehealth. You're next.

(Pause.)

CHAIR BAILET: Kelli, are you with us?

MS. GARBER: I'm muted. Hi. Can you hear me now?

CHAIR BAILET: Yes, we can.

MS. GARBER: Thank you.

I appreciate the opportunity to share some thoughts with the group and enjoyed the discussion. It was very informative, and I appreciate that.

I'm speaking today on behalf of nurse

practitioners, particularly the National Association of Pediatric Nurse Practitioners where we're experts in pediatrics and advocates for children.

As everyone has shared today, telehealth is an efficient and effective method of care delivery.

I've seen firsthand the difference it makes in the lives of children and families, particularly those with special health care needs and chronic conditions.

It's important that barriers to telehealth utilization continue to be removed, including those resulting from lack of reimbursement.

It's very important that any reimbursement modification be inclusive of advanced practice registered nurses and particularly nurse practitioners.

Nurse practitioners of all specialties provide quality, comprehensive care. Extending the reach of their care beyond clinic walls may

make a significant difference in improving health outcomes and health equity.

Including APRNs in telehealth practice can make an Alternative Practice Model more efficient and patient-centered.

As health care continues to shift towards value-based care, it's crucial that APRNs be included in payment models that are flexible, innovative, and improve patient outcomes. Telehealth can contribute to the success of these models.

Using various modalities of telehealth to extend the continuum of care may contribute to achieving the quadruple aim of improved outcomes, improved clinician experience, improved patient experience, and lower health care cost.

Using telehealth to reach patients where they are, such as children in school or in their homes, may improve health outcomes, reduce the frequency of unnecessary emergency department visits, reduce costs, and reduce missed work time for parents and class time for students.

It's time that we re-imagine health care. Embracing telehealth and being inclusive of nurse practitioners is essential to the future of health care in our country. Thank you.

CHAIR BAILET: Thank you, Kelli. And that actually concludes the public comment section of our meeting.

*** Committee Discussion**

I'd now like to turn it over to -- as we close out this incredible day, we have some time for the Committee members to discuss and reflect on what they've heard today.

The learnings from our sessions and discussions here today will be compiled and shared online and with the Secretary of HHS.

Similar to when we wrap up our deliberations in voting on proposals, I invite my fellow Committee members to share any additional insights or specific points that maybe you would like to emphasize in our report on telehealth. Thank you.

So I open it up to the Committee.

(Pause.)

CHAIR BAILET: Just anybody can just go ahead. You guys -- there's just a few of us here.

DR. WILER: I'll jump in, and thanks for the opportunity to ask questions.

I guess much like Grace did, I guess I should, for the record, disclose a potential conflict of interest in that I am a co-founder of our health system's CARE Innovation Center where we partner with digital health companies to grow and scale their submissions.

And I believe strongly that payer, provider, and technology partnerships are critically important to help us solve these issues.

And I think we heard some wonderful best practices that are working well. And I think alignment around identifying care models and the message is not one care model, it may be multiple care models based on patient preferences, is an important consideration.

And then how the payment model aligns with those care models, again, it may not be one solution, but it cannot be 20 solutions, right? At some point, there needs to be simplification of the process.

We have many tests of change that are working. I think COVID has given us the awesome opportunity to see when there is a crisis, we can move quickly to improve the health of our patients across the United States and ultimately our population.

So we can do it, and I hope that some of the tactical components that were described here, that we can highlight and leverage this as an opportunity to make some significant change or influence change.

CHAIR BAILET: Thanks, Jen.

Josh, do you want to go next?

(Pause.)

CHAIR BAILET: Josh, can you hear me?

DR. LIAO: Oh, yes. Sorry, Jeff. There was a little glitch on the web there.

So my comment builds on Jennifer's, and it's that the two things that really struck me from this last session was this idea of flexibility, but the need for simplicity.

And I don't think those are necessarily at odds on their faces, but it does highlight the potential tension between kind of having many different tests of change that can be useful and then moving towards a place where, as other have said, we can't have 20, 30, 40 solutions.

And so the thought I'm left with is this idea of sequencing and how we think about when, how, and where do we encourage more flexibility, perhaps the cost of simplicity, recognizing that, versus when and how do we move towards simple solutions that can be scaled, but recognizing that that may come at some level of less flexibility. So I'd like that to be reflected in the report.

CHAIR BAILET: Great. Thank you, Josh.

And I think we'll have time to sort of

look at the draft and make sure that the points that were raised by the panelists in both panel sessions get incorporated.

There were a lot of tactical comments that were made from security sort of tracking challenges, technology challenges, to more global concerns that were raised regarding payment parity, a patient-centered approach, as Harold pointed out, and interoperability and not -- the one thing that I think, Jay, you raised about the silo.

The last thing we need right now is creating a silo -- yet another silo. So you know, an electronic health records sinkhole or now it will be a telehealth sinkhole, we definitely don't want that.

And so here's an opportunity since we're starting -- you know, we're just putting up the tracks now, we're laying the tracks, we have an opportunity to get it right.

And so I'm hopeful that the guidance that we can provide in this document that we're

going to create will help us get to that end.

Any other comments? I didn't see anybody else raise their hand.

Grace?

VICE CHAIR TERRELL: Yeah, just one thing that's not specific about the actual topic today, but just an insight that I had with just the richness of this discussion as it relates to a topic by having not only the -- it's the very thoughtful comments from the previous submitters this morning to the expertise this afternoon created something I hope we can think very deeply about as a Committee as we're going forward with our ongoing, you know, processes and thinking through.

So -- and then we'll likely talk about that a little bit more in our administrative session among ourselves, but I just wanted to say in the public meeting that I, for one, found this to be rich and useful and beneficial and would certainly want to find out from the public and other, you know, other stakeholders whether

whatever work product comes out of this after we talk in more detail in the public meeting in December about this, as to whether this is a -- something that we need to do on an ongoing basis.

I believe it is, and we, as PTAC, of course will think about what might be our next thematic meetings, but this is our first.

And so I think it's going to be really important for us to understand from everybody, is this going to be useful going forward? I, for one, thought it was wonderful.

CHAIR BAILET: Thanks, Grace.

And I know, Lauran, you had a comment you wanted to make or a question.

MS. HARDIN: You know, this is incredibly rich, Jeff. There's a few themes that are really interesting to me.

So first of all, how aligned everyone was in their comments across sectors was very interesting to me.

And then how valuable telehealth has been with behavioral health is a theme that's

coming up around the country, which I didn't expect.

And then the emphasis on interprofessional, interdisciplinary, and interorganizational collaboration and design of that and what we look at with telehealth.

And then finally, the transformational value of including the perspective of startup costs and education or co-learning when we look at financing telehealth.

*** Closing Remarks**

CHAIR BAILET: Thanks, Lauran, and thanks everyone. I mean, this was a little bit of -- we were astronauts today.

This is the first time that PTAC has embarked on a session -- holding a session like this.

But, as Grace said, it's been incredibly rich, incredibly valuable. It will help sharpen our thinking and our approach to evaluating models and making recommendations on the go forward.

I want to thank everybody for participating today and members of the public, panelists, public commenters, and obviously my colleagues on the Committee.

We've covered a lot of ground today on a very important topic, and you can keep an eye out for our resulting compilation in the coming weeks.

We're also issuing another round of questions for public input, as Grace pointed out, and this time focused on telehealth.

And we will be posting those online and sending them out to the PTAC distribution listserv, which you can join on the ASPE PTAC website.

Thank you all for taking time out of your busy schedules to join us, please take care and be well, and this meeting is adjourned. Thank you.

(Whereupon, at 1:27 o'clock p.m. the meeting was adjourned.)

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Advisory Committee Virtual Meeting

Before: PTAC

Date: 09-16-20

Place: teleconference

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R Gross

Court Reporter