Physician-Focused Payment Model Technical Advisory Committee
Public Meeting Minutes

September 16, 2020
10:00 a.m. – 1:27 p.m. EDT
Virtual Meeting

Attendance*

Physician-Focused Payment Model Technical Advisory Committee (PTAC) Members

Jeffrey Bailet, MD, PTAC Chair (President and Chief Executive Officer, Altais)
Grace Terrell, MD, MMM, PTAC Vice Chair (President and Chief Executive Officer, Eventus WholeHealth)
Paul N. Casale, MD, MPH (Executive Director, NewYork Quality Care ACO)
Jay S. Feldstein, DO (President and Chief Executive Officer, Philadelphia College of Osteopathic Medicine)
Lauran Hardin, MSN, FAAN (Senior Advisor, Partnership and Technical Assistance, National Center for Complex Health and Social Needs, Camden Coalition of Healthcare Providers)
Angelo Sinopoli, MD (Chief Clinical Officer, Prisma Health)
Bruce Steinwald, MBA (President, Bruce Steinwald Consulting)
Jennifer Wiler, MD, MBA (Chief Quality Officer Denver Metro, UCHealth, and Professor of Emergency Medicine, University of Colorado School of Medicine)

PTAC Members in Partial Attendance

Joshua M. Liao, MD, MSc (Associate Professor, Medicine and Director, Value and Systems Science Lab, University of Washington School of Medicine)**

PTAC Members Not in Attendance

Kavita Patel, MD, MSHS (Vice President, Payer and Provider Integration, Johns Hopkins Health System)

Office of the Assistant Secretary for Planning and Evaluation (ASPE) Staff

Stella (Stace) Mandl, PTAC Staff Director
Audrey McDowell, Designated Federal Officer

ASPE Contractor Team, NORC at the University of Chicago (NORC)

Adil Moiduddin

Via Webex Webinar unless otherwise noted

****Via Conference Call***

List of Speakers, Public Commenters, and Handouts

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

   Adil Moiduddin, MPP, NORC at the University of Chicago

   Handouts

   - Public Meeting Agenda
   - Telehealth Overview Presentation
   - Telehealth Environmental Scan

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

   David Basel, MD, Avera Health
   Stetson Berg, MHA, University of New Mexico Health Sciences Center
   Jeffrey Davis, MS, American College of Emergency Physicians
   Lawrence Kosinski, MD, MBA, SonarMD, Inc.
   Barbara L. McAneny, MD, Innovative Oncology Business Solutions
   Heidy Robertson Cooper, MPA, American Academy of Family Physicians

   Handouts

   - Previous PTAC Proposal Submitters Panelists' Biographies
   - Questions/Topics to Guide Panel Discussions

3. **Panel Discussion with Subject Matter Experts (SMEs)**

   Sanjeev Arora, MD, MACP, FACG, University of New Mexico Health Sciences Center (Academic Research Perspective)
   Chad Ellimoottil, MD, MS, University of Michigan (Academic Research Perspective)
   Lewis Levy, MD, FACP, Teladoc Health (Telehealth/IT Perspective)
   Lee Schwamm, MD, Harvard Medical School, Partners Healthcare, and Massachusetts General Hospital (Provider Perspective and IT/Academic Research)
   Sophia Tripoli, MPH, Families USA (Patient Advocacy Perspective)
   Anne Tumlinson, ATI Advisory (Long-Term Care and Disability Perspective)
   Charles A. Zonfa, MD, MBA, SummaCare (Payer Perspective)

   Handouts

   - Subject Matter Experts (SMEs) Panelists' Biographies
   - Questions/Topics to Guide Panel Discussions

4. **Public Commenters**

   Harold Miller, MS (President and CEO, Center for Healthcare Quality and Payment Reform)
   Keshia Houston (Researcher)
   Kelli Garber, MSN (Lead Nurse Practitioner for School-Based Health and the Center for Telehealth at the Medical University of South Carolina)

[NOTE: A transcript of all statements made by PTAC members, submitter representatives, subject matter experts, and public commenters at this meeting is available on the ASPE PTAC website located at: http://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee].

The PTAC website also includes copies of the presentation slides and a video recording of the September 15-16, 2020 PTAC public meeting.

Welcome and Telehealth Session Overview

Jeffrey Bailet, PTAC Chair, welcomed members of the public to the second day of the September 2020 virtual PTAC public meeting and provided an overview of the agenda for the Telehealth session. Chair Bailet explained that, given the far-reaching impact of the recent public health emergency (PHE), the Committee believed that it is an optimal time to investigate lessons learned from recent experiences with telehealth. He noted that the session will look at the work of previous submitters who included telehealth in their proposed physician-focused payment models (PFPMs), and how they might inform future policymaking. He indicated that this represents an opportunity to learn more from the field about how previous models have incorporated telehealth and how telemedicine may impact alternative payment models. Chair Bailet also noted that in addition to reviewing the previous models that have incorporated telehealth, PTAC commissioned an environmental scan on telehealth from the ASPE support contractor, NORC at the University of Chicago (NORC), which is available on the ASPE PTAC website.

Presentation: Overview of PTAC Proposals with Telehealth Components

Adil Moiduddin, Senior Vice President at NORC, provided an overview of the PTAC proposals that included a telehealth component. Between December 2016 and March 2020, 36 proposals were submitted to PTAC. Excluding proposals that are currently under review, 18 of these proposals included telehealth as a component. This includes five proposals that included telehealth as a central feature, nine that included telehealth as an aspect of care delivery or the payment model, and four that included telehealth as an optional component of the model or mentioned the potential for using telehealth services under the model. This analysis used the Health Resources and Services Administration (HRSA) Office for the Advancement of Telehealth (OAT) definition for telehealth, defined as "the use of electronic information and telecommunication technologies to support long-distance clinical health care; patient and professional health-related education; public health; and health administration." It includes telehealth services authorized through Medicare as telehealth or telecommunications, which may include live, or synchronous exchange of information, and use of asynchronous exchange of information.

Key findings from the analysis of PTAC proposals with a telehealth component included the following:

- The proposals reviewed varied by populations served and settings of care.
- The proposals envisioned the use of different telehealth modalities, with many incorporating more than one telehealth.
- The submissions emphasized that telehealth is a tool that can be used as part of a broader model to improve access to care and quality of care.
- The proposals incorporate a variety of different payment models.
- PTAC made favorable assessments of telehealth in six reports to the Secretary (RTS), highlighting the data-sharing opportunities created by health information technology (HIT) and telehealth; the opportunities to use telehealth to create efficiencies for providers; and the use of telehealth to support higher quality care, enable earlier intervention, and support reductions in emergency department (ED) visits, hospitalizations, and mortality.

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

Chair Bailet moderated the panel discussion of previous proposal submitters. He noted that the previous submitters were invited to share their insights, and that this discussion does not represent a redeliberation of their proposals. However, the information gleaned from NORC's review and this discussion is expected to inform PTAC's review of future proposals and its recommendations and comments to the Secretary on physician-focused payment models, particularly relating to telehealth and alternative payment models (APMs). Chair Bailet introduced the participating panelists noted that full biographies of each panelist can be found on the ASPE PTAC website:

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

The panelists were asked to describe how telehealth was incorporated into their respective proposed PFPMs; to discuss emerging lessons from their recent experience delivering health care under the PHE; and to share their most critical insights regarding telehealth and APMs. They were also asked to reflect on best practices related to adopting telehealth, as well as additional barriers to effective use of telehealth. The following are highlights of some of the key themes that were discussed by each panelist.

- Barbara L. McAneny explained that the *Making Accountable Sustainable Oncology Networks MASON* proposal grew out of a 2012 Center for Medicare & Medicaid Innovation (CMMI) Health Care Innovation Award. Dr. McAneny noted that telehealth was a more limited tool when the MASON proposal was submitted to PTAC, because patient access required being at a clinic. However, she observed that after the PHE, providers have been able to use telemedicine for patients in their homes, particularly by means of telephone in rural and tribal areas that lack broadband for using visual telehealth. Dr. McAneny stated that they were able to use telemedicine as a valuable frontline tool for assessing appropriate site of service to determine which patients needed an in-person visit, limit the number of hospitalized patients and thus reduce exposure to COVID-19 among cancer patients. She also noted that limiting the number of hospitalized patients has implications for savings.

  However, Dr. McAneny expressed concerns regarding the need to proceed with caution with telehealth due to: the significant value of a physical examination in certain cases, the risk of exacerbating disparities for certain populations (such as those who cannot afford a smartphone or do not have a computer, those who live in areas without broadband access, or those who are sick without a caregiver to set up the telemedicine visit); and potential liability and risks associated with treating patients whom the provider does not know through a pre-existing

relationship. Dr. McAneny stated that APMs should take into account the cost of providing services to improve care for the most vulnerable populations as part of payment to avoid creating disincentives to care for these patients. She also noted the importance of maintaining coverage for telehealth care for patients living at home.

Dr. McAneny noted the need for accurate cost accounting to understand the true cost of telehealth implementation and use, including resources required to provide services to patients adversely affected by social determinants of health or chronic health conditions. She noted that use of telehealth does not reduce the need for staff time, and under FFS, adoption of telehealth does not generate revenue.

- Heidy Robertson Cooper noted that telehealth was an optional component in the *Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care* proposal as the model sought to maximize flexibility for participating practices to deliver care in ways that made the most sense for their patients – including telehealth along with other modalities.

  Ms. Robertson Cooper cited a steep increase in the number of family physicians using telehealth after the PHE. She cited this as an indication that prior inflexibility in payment led to reduced adoption of telehealth. She emphasized the importance of continued payment flexibility, as well as the shift to a payment model that is less reliant on fee-for-service. In particular, she stated that a prospective, risk-adjusted APM can help primary care providers (PCPs) engage with an interdisciplinary care team and cover wrap-around services.

  Ms. Robertson Cooper emphasized challenges faced by PCPs undergoing a rapid switch to telehealth. Ms. Robertson Cooper also cited the lack of alignment between payers on telehealth, noting that the average family physician works with 14 different payers. She noted that providers have been schedules, educating patients, conducting pre-telehealth visit testing, and creating backup plans to go to audio-only as needed. Ms. Robertson Cooper explained that PCPs have developed approaches to determining the conditions when a patient must come for a physical visit.

- Stetson Berg noted that telehealth was an integral component of the *ACCESS Telemedicine: An Alternative Healthcare Delivery Model for Rural Cerebral Emergencies* proposal. The proposal focuses on providing remote assessment of neuroemergent conditions and trauma at hospitals that lack neurologists and neurosurgeons, and providing education on neurological conditions to rural hospital providers at 22 sites via telehealth – resulting in estimated savings of over $250 million in the last five years in transportation alone.

  Mr. Berg noted the value of telehealth in supporting resilience in rural areas and noted UNMHSC's use of 24/7 call centers to foster retention of rural patients and continuing education for rural clinicians. He described the Medicare waivers as having a limited effect, not adequate to sustain their model. Mr. Berg also noted that they have faced difficulties with billing-complexity related to the originating site fee and provider consultation fees and with collecting a copayment from the patient. They provide services to rural hospitals on a global basis using a cost per consultation model.

Mr. Berg focused on the need to expand services in rural and frontier areas, provide educational resources to support providers, and support funding for originating sites. He also emphasized focusing on solutions to deliver education so that providers may retain and treat patients more confidently using telehealth.

- Jeffrey Davis noted that the *Acute Unscheduled Care Model (AUCM): Enhancing Appropriate Admissions* proposed model was structured as a bundled payment model that included a telehealth waiver that would allow emergency physicians to provide follow-up telehealth services when the beneficiary has been discharged into their home or transferred to another facility to avoid follow-up ED visits or inpatient admissions.

  Mr. Davis noted that the easing of geographic restrictions associated with payment for telehealth and inclusion of emergency medical screening as covered telehealth services have helped to preserve personal protective equipment, reduced exposure to COVID-19, and facilitated follow-up after ED discharge. He noted that an APM would still be needed to achieve alignment of incentives related to non-telehealth components of their model even if the PHE telehealth-related waivers remain in force.

  Mr. Davis highlighted concerns relating to uncertainty regarding payment policy following the PHE. Mr. Davis noted that, in the case of ED care, telehealth can help ED physicians follow up appropriately, and an APM can provide the needed financial stability and incentives.

- Lawrence Kosinski noted that telehealth was a core part of the *Project Sonar* proposal. Dr. Kosinski described the proposal as including the structured telemonitoring of patients with chronic conditions (identified through monthly surveys of an attributed population), and benchmarking based on symptom scores, and extending to care coordination. He also described how use of claims data can link care coordination to changes in utilization. He noted that the development of the Sonar platform has created statistically significant savings in total cost and a decline in hospitalizations, ED visits, and inpatient care.

  Dr. Kosinski stated that COVID-19 reinforced his understanding of barriers to care and the intensified need for telehealth. He stated that telehealth must move beyond being reactive care to be proactive, and flexibility is needed to enable providers to be proactive in managing patient care. For example, they use monitoring to proactively address patient reluctance to seek care for chronic conditions; the barrier of care avoidance may be lessened through remote symptom monitoring. He sees the Medicare waivers as having enabled their practices to deliver care. However, he also discussed the need for a specialty APM that would help practices to develop the infrastructure necessary for value-based care, as well as the need for timely performance data. Dr. Kosinski also stated that there is a dearth of knowledge about interventions required to make best use of telehealth for cohorts of patients with different levels of comfort using technology.

- David Basel stated that the proposed model had its origins in a CMMI Health Care Innovation Award. Dr. Basel indicated that the l *Intensive Care Management in Skilled Nursing Facility Alternative Payment Model (ICM SNF APM)* proposal used a geriatric-led multidisciplinary team – including social workers, pharmacists, geriatric-trained advance practice providers, behavioral health, and infectious disease – to deliver those services into nursing homes via two-way audio/visual technology. He noted that telemedicine has enabled the submitter to scale,

providing services to over 75 nursing homes in South Dakota, as well as a lot of systematic education, and explained that providing this kind of care using a multi-disciplinary approach would have otherwise been impossible in a rural setting. Based on internal data, they have estimated a 30 percent reduction in ED visits and $342 per member per month (PMPM) savings for enrolled Medicare members.

Dr. Basel stated that an APM is needed to support a cultural shift to routine use of telehealth to provide ongoing access to a multidisciplinary team of providers for patients and staff. His organization leveraged presence in over 60 skilled nursing homes (SNFs) to fuel cultural transformation that includes 24/7 eLongTermCare coverage by the team. He stated that the Medicare waivers do not cover facility-wide interventions and culture change, since they are still based on an episodic, point-in-time payment for specific services. Dr. Basel stated that he pays for the eLongTermCare intervention out of his organization's ACO shared savings because this telehealth intervention saves the ACO money by reducing ED transfers, reducing hospitalizations, and keeping patients healthier.

Dr. Basel noted barriers associated with the challenge of obtaining and maintaining licensure to practice in each state. Dr. Basel also highlighted barriers associated with billing for telehealth under fee-for-service or even in the context of an episode-based payment model or care management fee. Some of these complexities were related to the originating site fee and provider consultation fees and with collecting a copayment from the patient. For this reason, his organization provides services to nursing homes on a global basis using a monthly fee model. He noted that using a value-based contract would mitigate these barriers.

The Committee recessed at 11:36 a.m. EDT and reconvened at 11:51 a.m. EDT.

Panel Discussion with Subject Matter Experts

Vice Chair Grace Terrell moderated the panel. The participating panelists were:

- Sophia Tripoli, MPH, Families USA (Patient Advocacy Perspective)
- Anne Tumlinson, ATI Advisory (Long-Term Care and Disability Perspective)
- Lee Schwamm, MD, Harvard Medical School, Partners Healthcare, and Massachusetts General Hospital (Provider Perspective and IT/Academic Research)
- Lewis Levy, MD, FACP, Teladoc Health (Telehealth/IT Perspective)
- Chad Ellimoottil, MD, MS, University of Michigan (Academic Research Perspective)
- Sanjeev Arora, MD, MACP, FACG, University of New Mexico Health Sciences Center (Academic Research Perspective)
- Charles A. Zonfa, MD, MBA, SummaCare (Payer Perspective)

The panelists were asked to share lessons learned regarding how telehealth affected access to services during the PHE; challenges as well as technical, clinical practice or geographic limitations or barriers; and potential advice regarding APMs and telehealth. The following are highlights of some of the key themes that were discussed by each panelist.

- Ms. Tripoli stated that healthcare providers have taken drastic actions to reorient workforces, modify facilities, and prioritize critical services in order to provide safe care for individuals with COVID-19 while facing significant revenue shortfalls due to large drops in utilization. She

indicated that the expansion and reimbursement of telehealth services has helped to generate some revenue in the short term. However, she emphasized that providers using value-based payment have been more financially stable and were able to leverage telehealth services more quickly to develop an effective pandemic response and better meet the needs of their patients than were providers who relied on FFS reimbursement. Ms. Tripoli stated that this is because the payments to practices using APMs are built to support a wide variety of capabilities that are not currently supported under FFS such as care coordination staff, patient engagement tools (including 24/7 help lines), data analytic capabilities, and infrastructure needs to support telehealth (including remote monitoring and home-based care). She also discussed the importance of integrating telehealth into existing APMs and value-based arrangements, and allowing providers to provide whatever set of services they need to provide to meet their patients' needs, therefore reducing silos and reducing the fragmentation of care.

Ms. Tripoli also indicated that patients continue to face substantial barriers related to accessing telehealth and virtual care services – including patients lacking access to a cell phone, or a phone or computer with video capability, or language interpreter services, or internet and broadband services. She also emphasized the importance for the healthcare system to be accurately collecting data on race, ethnicity and primary language in order to meet the needs of all of the people it serves and build and implement equity payment incentives.

Ms. Tripoli also highlighted the need for a concrete and sophisticated way to ensure that telehealth and virtual care services are meeting quality standards.

Ms. Tripoli also discussed the need for improved data sharing and data interoperability across and within the healthcare system. Ms. Tripoli emphasized the need the flow of interoperable data between providers; the integration of telehealth into existing APMs; and leveraging new and existing APMs to reduce the digital divide. For example, she suggested that APMs could assist in getting direct support professionals into the care teams to work directly with patients.

- Ms. Tumlinson began by discussing the importance of understanding that the "long term care" population includes individuals that have difficulty performing basic activities of daily living, and that 75 percent of the five to seven million older adults who are in this population are living in the community in single-family dwellings, not in nursing homes or assisted living. She indicated that there have historically been challenges in scaling models that serve this population effectively and reduce the use of a hospital setting. However, as a result of the pandemic there have been some high-functioning care models with primary care-led interdisciplinary teams under risk-based payment models that have been able to rapidly deploy telehealth technologies and use virtual care in order to deliver that kind of interdisciplinary team model to serve the long-term care population.

  Ms. Tumlinson also stated that the current way in which we have structured APMs (including shared savings) may not be sufficient to encourage a large physician practice in a market to embrace virtual care, invest in telehealth, and build the care delivery infrastructure within their organization to be able to address the needs of populations with complex care needs and lots of interacting with the medical care or long-term care systems.

  Additionally, Ms. Tumlinson noted that the long-term care population is going to get stranded without dedicated investment in APMs that support primary care and multidisciplinary teams.

She also emphasized that telehealth is not the solution, it is a tool that will help the solution to work in scale.

- Dr. Schwamm discussed the importance of ensuring that telehealth-related data dashboards and approaches to measuring quality and variation in adoption address social determinants of health.

  Dr. Schwamm also noted that some patients may have concerns regarding privacy and location, which may make them resistant to the idea of downloading specialized applications to conduct video. Therefore, he emphasized the need to balance security with simplicity in developing solutions. Dr. Schwamm also stated that while his organization's virtual care solutions restored 60 percent of the volume, they did not see an increase in the use of telehealth for frivolous purposes.

  Dr. Schwamm indicated that in addition to patients who have limited digital literacy or English proficiency or access to technology, there are also some patients who have cognitive, visual or physical impairments that could make it difficult for them to join a video call alone. Therefore, he agreed with prior comments about the need to think about the environment of care around the patient in a virtual environment if the patient is at home.

  Dr. Schwamm also emphasized the importance of audio-only services, stating that it is a health equity issue. He stated that that providing lower reimbursement or no reimbursement for audio-only services would build structural inequity into the payment system and disenfranchise a lot of patients. Dr. Schwamm indicated that during the pandemic, audio-only services were particularly effective for treating patients with mental illness or substance use disorders; and keeping pediatric patients out of the doctor's office when appointments were not needed, therefore reducing everyone's risk of exposure.

  Dr. Schwamm also discussed the need for secure and predictable financing for telehealth services, and safe and secure and HIPAA-compliant platforms in which to provide the services.

  Dr. Schwamm suggested that as a first step toward beginning to address the variation in how telehealth is applied in local settings while avoiding silos, there is a need for integrated delivery care networks to understand how to deliver care in a way that incorporates virtual care / telehealth effectively. However, he also stated that organizations like Teladoc can play an important role for patients who are not part of an integrated delivery care networks.

  Dr. Schwamm also discussed the benefits of partnerships such as demonstration projects with CMS and value-based care and alternative payment model contracts, but suggested creating lower barriers to entry rather than requiring a lot of up-front investment and a possibility of shared savings. He also stated that it is important for health systems to have five years of predictability in reimbursement in order to be able to make the necessary investments, which may not be possible with a one-year or two-year demonstration.

  Dr. Schwamm encouraged removing the barriers to virtual care services so they are treated similarly to in-person care; expanding patients' access to either in-person care, virtual care, or a mixture of the two; and making the system simple so that patients are not receiving surprise

bills and providers and facilities are not at constant risk of noncompliance when they are simply trying to do the right thing.

- Dr. Ellimoottil stated that while there was a strong demand for telehealth among patients and providers during the PHE, the demand was not overwhelming, indicating that resistance to change is still a big issue in healthcare. For example, based on data from his health system and national Epic data, he indicated that there was about a 50 to 70 percent drop in outpatient in-person care, and only about 20 percent of that was really salvaged through telehealth. Dr. Ellimoottil also noted that the degree of telehealth use that was clinically appropriate varied by specialty, with higher levels for mental health.

  Dr. Ellimootil stated that it is important to address the digital divide. He noted that in addition to the digital divide, there is also a perception among patients that the quality of care through telehealth may not be equivalent to inpatient care. He also noted that with regard to the audio-only and the other types of modalities, in their 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. He stated that there is the digital divide portion of this issue, but there is also a patient preference portion, which is also important to consider.

  Dr. Ellimoottil also stated that when thinking about alternative payment models, it is important to have coordination between telehealth and in-person interventions in order to achieve desired outcomes. For example, if there is a technology that monitors chronic disease and sends a signal to a doctor, the bundle of services should include an intervention that is designed to avoid sending the patient to the ER.

  Dr. Ellimootil also discussed the need to consider the impact of telehealth on disparities (rural vs. non-rural, low-income vs. higher income, minority groups, populations over 80, etc.), the impact of telehealth on cost, and the association of telehealth with clinical outcomes. Regarding disparities, Dr. Ellimootil noted that usage of telehealth is influenced by the digital divide, which affects both patients and providers. He indicated that having data regarding what happened during the pandemic can give policymakers insight regarding potential interventions that can be made relating to these populations, and provided several examples.

  Additionally, Dr. Ellimootil emphasized the importance of simplicity regarding policies relating to telehealth coverage and regulations, and the importance of ensuring that the financial gain from using telehealth outweighs the costs of implementing it – whether in a FFS environment or in an APM. He also discussed the importance of the entire episode of care when determining telehealth reimbursement – including remote monitoring, as well as the interventions that are needed to help achieve the desired outcome (e.g. community paramedics, home infusions, etc.)

- Dr. Levy stated that during the second quarter of 2020, his organization went from seeing about 10,000 telehealth patients per day in the U.S. to 20,000 patients per day, including a great increase in mental health visits. His organization is also seeing increased comfort in using telehealth among providers; increased interest in implementing more virtual care services among large employers; and increased interest in using virtual care among consumers, as well as an interest in having the virtual care integrated with their in-person care.

Dr. Levy highlighted findings from the National Committee for Quality Assurance (NCQA) Task Force on Telehealth Policy, which studied the use of telehealth during the pandemic. These findings included: reduced wait times and issues around travel, improved quality outcomes and greater adherence to care plans under telehealth, and no evidence of increased in utilization and volume of care. Dr. Levy also noted that the NCQA Task Force believed that existing policies defining requirements relating to site of care should be eliminated, that consideration should be given to universal licensing of providers; and that many of the relaxations around Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements should be put back into place in a post-COVID era.

Dr. Levy also agreed with the need to address issues relating to social determinants of health. He stated that his organization has been strong advocates that telehealth should always embrace an audio-only option, and has always endorsed having language lines and interpreters. He also stated that with regard to the elderly population, his organization has had a caretaker program where a family member can be brought on to help through the telehealth encounter with the elderly individual.

Dr. Levy also stated that careful attention toward quality of care is critical to his organization's success, and that they have been working closely with a number of organizations to ensure that with scale come improvements in overall quality of care.

Additionally, Dr. Levy discussed the importance of interoperability, ensuring that any provider whether in a brick-and-mortar or virtual setting has access to information, and that the information is not siloed in individual hospitals and health systems, but is more universally shared. He noted that achieving better integration will require more attention toward value-based care, and agreed that the goal is not to create another silo for telehealth and/or freestanding telehealth companies.

Dr. Levy stated that while value-based care is a natural home for telehealth, but it also has a role in FFS related to ensuring access to super specialists and subspecialists who practice in academic medical centers.

Dr. Levy encouraged parity regarding reimbursement between in-person and virtual care, and supporting the infrastructure that facilitates the integration of virtual care and in-person care in order to address issues around interoperability.

- Dr. Zonfa stated that telehealth is here to stay, and is a valuable tool, but the healthcare system is still struggling to see where it fits. Dr. Zonfa indicated that while there was very slow adoption of telehealth services before the PHE, he is starting to observe a cultural shift among providers in his region now that it has been demonstrated that effective care can be delivered through a nontraditional face-to-face visit. However, he noted that the cultural shift was still in progress among providers and patients – noting that the telehealth adoption rate had risen to about 60 percent of office visits at the height of the pandemic, and has now normalized at about 20 percent of visits within his medical group.

  Dr. Zonfa stated that one of the main lessons that was learned through the PHE from the payer perspective is the value of communicating effectively with providers and patients on how to use and bill for telehealth services. He also noted that his organization has embraced value-based

models and looked for ways to pay for care through alternative models, not just fee-for-service, face-to-face visits.

Dr. Zonfa indicated that while he has not seen any abuse of telehealth visits, there is variability in what a telehealth visit means. He stated that it would be nice to progress toward greater standardization for a telehealth visit (e.g., audio-only, video-only, the components that are needed, the various different levels of what a telehealth visit pays, and the triggers needed for a face-to-face visit). Dr. Zonfa also stated that increased standardization is needed relating to the guidelines for a telehealth visit, and what represents an effective telehealth visit from a quality standpoint. Additionally, Dr. Zonfa discussed the importance of ensuring coordination so that other providers in the care delivery network are aware of what happens in a telehealth visit. Dr. Zonfa also discussed the importance of changing the payment model and providing some type of funding for the network or for providers to deliver telehealth services, while also having a concrete conversation about: what services the payer purchased, what services will be provided, and how to ensure that the services are not completely disjointed from the rest of the care delivery system.

Additionally, Dr. Zonfa encouraged supporting telehealth models of care that meet guidelines for appropriate use and ensure quality, and supporting a payment model that allows flexibility because different geographies have different needs.

- Dr. Arora emphasized the role that use of telehealth can play in facilitating technology-enabled collaborative learning for provider education, which can help to quickly move new information and best practices from experts to providers who are at the front line caring for patients in their communities. He discussed Project ECHO, in which teams of experts at regional medical centers use one-to-many videoconferencing to provide ongoing knowledge sharing, case-based learning and telementoring to rural providers – with a goal of ensuring that the right knowledge exists in the right place at the right time. During the COVID-19 pandemic, almost 1,000 training sessions for more than 200,000 public health professionals, doctors and nurses have been conducted on ECHO to answer various questions.

  Dr. Arora stated that in addition to using traditional telemedicine to provide direct care, there is a need for alternative payment models, value-based care, or other innovative ways to make payment accessible for providers participating in ECHO projects and academic medical centers that run ECHO projects.

  Dr. Arora noted the importance of moving to APMs or value-based care where the system is responsible for the entire care of the patient, quality of care, patient satisfaction – then integration becomes a natural consequence.

Public Comment Period

Vice Chair Terrell thanked the panelists and opened the floor for public comments. The following individuals made comments:

1. Harold Miller, MS (President and CEO, Center for Healthcare Quality and Payment Reform)
2. Keshia Houston (Researcher)
3. Kelli Garber, MSN (Lead Nurse Practitioner for School-Based Health and the Center for Telehealth at the Medical University of South Carolina)

Committee Discussion

Chair Bailet stated that the findings from the various discussions during the Telehealth session will be shared online and with the Secretary of HHS. He invited the Committee members to share any insights that they would like to emphasize in PTAC's report on telehealth. Committee members made the following additional comments.

- COVID-19 has provided an opportunity that can be leveraged to improve the health of patients across the United States.
- The importance of payer, provider and technology partnerships are critically important to assist in solving the issues relating to telehealth that have been discussed.
- The panelists highlighted some best practices relating to telehealth that are working well.
- An important consideration regarding alignment around identifying care models is that there may not be one care model, it may be multiple care models based on patient preferences.
- Additionally, in considering how the payment model aligns with those care models, it may not be one solution, but it cannot be 20 solutions. At some point, there needs to be simplification of the process.
- There is a potential tension between the needs for flexibility and simplicity Therefore, it will be important to think about when, how and where to encourage more flexibility, perhaps at the cost of simplicity; versus when and how to move towards simple solutions that can be scaled, recognizing that may come at some level of less flexibility.
- Ensuring that the points that were raised by the panelists in both panel discussions get incorporated, including how aligned everyone was in their comments across sectors.
- Addressing tactical comments that were made relating to security, tracking challenges, and technology challenges; as well as more global concerns regarding payment parity, a patient-centered approach, interoperability, and avoiding creating another silo.
- Noting how valuable telehealth has been with behavioral health.
- Highlighting the emphasis on interprofessional, interdisciplinary, and interorganizational collaboration and design in the context of telehealth.
- Considering the transformational value of including the perspective of startup costs and education or co-learning when considering the financing of telehealth.

Additionally, Vice Chair Terrell stated that the richness of the panel discussions were a valuable addition to PTAC's administrative processes and suggested that the Committee should talk in more detail at its next public meeting in December 2020 regarding next steps.

Closing Remarks

Chair Bailet thanked all of the panelists and the public commenters for their valuable contributions and insights, which will help to inform the Committee's feedback on proposed models and recommendations moving forward. Chair Bailet noted that the Committee will be issuing another round of questions for public input on telehealth, via the ASPE PTAC website and Listserv.

The public meeting adjourned at 1:27 p.m. EDT.

Approved and certified by:

//Audrey McDowell//
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Audrey McDowell, Designated Federal Officer
Physician-Focused Payment Model Technical
Advisory Committee

11/10/2020
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Date

//Jeffrey Bailet//
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Jeffrey Bailet, MD, Chair
Physician-Focused Payment Model Technical
Advisory Committee

11/6/2020
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Date