

# Physician-Focused Payment Model Technical Advisory Committee

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November 25, 2019

Alex M. Azar II, Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

Dear Secretary Azar:

On behalf of the Physician-Focused Payment Model Technical Advisory Committee (PTAC), I am pleased to submit PTAC's comments and recommendation to you on a physician-focused payment model (PFPM), *ACCESS Telemedicine: An Alternative Healthcare Delivery Model for Rural Cerebral Emergencies (ACCESS Telemedicine)*, submitted by the University of New Mexico Health Sciences Center (UNMHSC). These comments and recommendation are required by section 1868(c) of the Social Security Act, which directs PTAC to: 1) review PFPMs submitted to PTAC by individuals and stakeholder entities; 2) prepare comments and recommendations regarding whether such models meet criteria established by the Secretary of Health and Human Services (HHS); and 3) submit these comments and recommendations to the Secretary.

With the assistance of HHS' Office of the Assistant Secretary for Planning and Evaluation (ASPE), PTAC's members carefully reviewed the *ACCESS Telemedicine* proposal (submitted to PTAC on February 13, 2019). PTAC also reviewed supplemental information on the model provided by the submitter and considered related issues in payment and care delivery, as well as relevant research findings. At a PTAC public meeting held on September 16, 2019, the Committee deliberated on the extent to which this proposal meets the criteria established by the Secretary in regulations at 42 CFR § 414.1465 and whether it should be recommended.

PTAC recommends the *ACCESS Telemedicine* proposal to the Secretary for further development and implementation as a payment model as specified in PTAC's comments (which are reflected in this report). The Committee finds that the proposal meets all 10 of the Secretary's criteria for PFPMs and deserves priority consideration based on the scope, quality and cost, and health information technology criteria. PTAC believes that the proposal addresses the important problem of limited access to specialist care for neurological emergencies, such as suspected strokes and head injuries, in rural areas.

The Committee also commends the proposed model for its use of new technology to provide care that potentially reduces duplication of resources and unnecessary transfers to other hospitals while contributing to the financial viability of rural and community hospitals. The proposed model benefits patients and families by increasing access to high-quality, timely care through telemedicine-based consultations with neurologists and neurosurgeons. These consultations allow local providers to identify which cases require transfer and enable patients to receive treatment in their own community when appropriate.

The Committee agrees that changes in current payment systems are needed in order to support this approach for increasing access to specialist care for emergencies. However, PTAC believes that several aspects of the specific payment model that has been proposed require further development or revision, including the set of services in the payment bundle, how quality of the services would be monitored, which conditions and diagnosis codes would be eligible, and what payment amounts would be appropriate. PTAC also noted several ways the proposed payment model differs from approaches used in other Medicare payment systems. PTAC recommends that these features be reconsidered to determine if they are necessary and appropriate, specifically: allowing payments to differ based on provider specialty (neurology vs. neurosurgery); bundling and paying for elements not historically paid by Medicare fee-for-service (FFS) (e.g., external telemedicine platform, on-call availability, infrastructure costs); and paying the entity that is requesting the service (i.e., the rural hospital) rather than the entity that is actually delivering the consultation service.

The members of PTAC appreciate your support of our shared goal of improving the Medicare program for both beneficiaries and the providers who care for them. The Committee looks forward to your detailed response.

Sincerely,

//Jeffrey Bailet//

Jeffrey Bailet, MD

Chair

Attachments

# REPORT TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

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Comments and Recommendation on  
*ACCESS Telemedicine: An Alternative Healthcare Delivery Model for  
Rural Cerebral Emergencies*

November 25, 2019

## About This Report

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

This report contains PTAC's comments and recommendation on the PFPM proposal *ACCESS Telemedicine: An Alternative Healthcare Delivery Model for Rural Cerebral Emergencies*. This report also includes: 1) a summary of PTAC's review of the proposal; 2) a summary of the proposed model; 3) PTAC's comments on the proposed model and its recommendation to the Secretary; and 4) PTAC's evaluation of the proposed PFPM against each of the Secretary's criteria for PFPMs. The appendices to this report include a record of the voting by PTAC on this proposal, the proposal submitted by the University of New Mexico Health Sciences Center, and additional information on the proposal submitted subsequent to the initial proposal submission.

## **SUMMARY STATEMENT**

PTAC recommends the *ACCESS Telemedicine* proposal to the Secretary for further development and implementation as a payment model as specified in PTAC's comments (which are reflected in this report). The Committee finds that the proposal meets all 10 of the Secretary's criteria for PFPs and deserves priority consideration based on the scope, quality and cost, and health information technology criteria. PTAC believes that the proposal addresses the important problem of limited access to specialist care for neurological emergencies, such as suspected strokes and head injuries, in rural areas. The Committee also commends the proposed model for its use of new technology to provide care that potentially reduces duplication of resources and unnecessary transfers to other hospitals while contributing to the financial viability of rural and community hospitals. The proposed model benefits patients and families by increasing access to high-quality, timely care through telemedicine-based consultations with neurologists and neurosurgeons. These consultations allow local providers to identify which cases require transfer and enable patients to receive treatment in their own community when appropriate.

The Committee agrees that changes in current payment systems are needed in order to support this approach for increasing access to specialist care for emergencies. However, PTAC believes that several aspects of the specific payment model that has been proposed require further development or revision, including the set of services in the payment bundle, how quality of the services would be monitored, which conditions and diagnosis codes would be eligible, and what payment amounts would be appropriate. PTAC also noted several ways the proposed payment model differs from approaches used in other Medicare payment systems. PTAC recommends that these features be reconsidered to determine if they are necessary and appropriate, specifically: allowing payments to differ based on provider specialty (neurology vs. neurosurgery); bundling and paying for elements not historically paid by Medicare fee-for-service (FFS) (e.g., external telemedicine platform, on-call availability, infrastructure costs); and paying the entity that is requesting the service (i.e., the rural hospital) rather than the entity that is actually delivering the consultation service.

## **PTAC REVIEW OF THE PROPOSAL**

The *ACCESS Telemedicine* proposal was submitted to PTAC on February 13, 2019. The proposal was first reviewed by a Preliminary Review Team (PRT) composed of three PTAC members (Len M. Nichols, PhD; Rhonda M. Medows, MD; and Grace Terrell, MD, MMM). The PRT conducted its review of the proposal between March 27, 2019 and August 9, 2019. The proposal was also posted for public comment. The PRT's findings are documented in the PRT Report to PTAC on the *ACCESS Telemedicine* proposal, dated August 9, 2019. The submitter provided a written response to the PRT Report on August 30, 2019, with updated program statistics from internal UNMHSC data sources. At a public meeting held on September 16, 2019, PTAC deliberated on

the extent to which the proposal meets the criteria established by the Secretary in regulations at 42 CFR § 414.1465 and whether it should be recommended to the Secretary for implementation. The submitter and members of the public were given an opportunity to make statements to the Committee at the public meeting. Remaining sections of this report provide a summary of the proposal, PTAC's comments and recommendation to the Secretary on the proposal, and the results of PTAC's evaluation of the proposal using the Secretary's criteria for PFPMs.

## **PROPOSAL SUMMARY**

The *ACCESS Telemedicine* program began as a Center for Medicare & Medicaid Innovation (CMMI) Health Care Innovation Award (HCIA). Using HCIA funds, UNMHSC developed and implemented the *ACCESS Telemedicine* model with 17 hospitals in New Mexico. The model aims to expand access to neurological and neurosurgical expertise in rural hospitals through telemedicine. Specifically, *ACCESS Telemedicine* uses a two-way, audiovisual telehealth platform to connect providers in rural hospitals and other facilities to neurologists and neurosurgeons who can assist in evaluating patients presenting with cerebral emergencies such as suspected stroke and head injuries. Rapid decision-making and timely initiation of treatment are critical for neurological emergencies. In areas lacking specialists trained in neurology, patients presenting for cerebral emergencies may be unnecessarily transferred to tertiary care facilities for evaluation and treatment, which can be costly and lead to delays in care. By connecting providers in rural and community hospitals to neurological and neurosurgical specialists, the *ACCESS Telemedicine* program in New Mexico has been able to reduce unnecessary transfers and improve timeliness of care.

Under the *ACCESS Telemedicine* model, providers may request a consultation with either a neurologist or neurosurgeon using an online platform. The system then connects them with an available specialist who provides consultation on the case. Specialists are able to view digitally transferred imaging and conduct verbal or visual assessment using audio or video conferencing. The consulting physician provides recommendations on treatment to the requesting provider, who ultimately decides on a plan of care for the patient. The requesting provider can, at no additional cost, have follow-up consultations on the same case within 24 hours of the initial request. All other health care services provided to the patient, outside of the telehealth consultation, are billed through existing mechanisms.

Beginning in January 2019, the New Mexico Medicaid program implemented payments to support the *ACCESS* program using modifiers to existing billing codes, including different modifiers for neurology versus neurosurgery consultations. The Medicaid coverage applies to Medicaid FFS and Centennial Care Medicaid managed care enrollees. Dual eligible Medicare-Medicaid beneficiaries are not eligible due to Medicare being the primary payer for these

individuals. The submitter also indicated in the proposal and additional information that it is working with other health care payers, including Medicare Advantage plans, to incorporate *ACCESS Telemedicine* into their covered services.

Although Medicare FFS covers telemedicine services, the proposal asserts that Medicare telehealth reimbursement is insufficient to cover the full cost of delivering services for cerebral emergencies, particularly the underlying technology platform costs. Under current Medicare provisions, Medicare telehealth payment to distant site physicians for consultations provided to patients in an originating site emergency department (ED) or initial inpatient assessment ranges from \$101.27 to \$204.35 for single consultations from 30 to 70 minutes, respectively. The same payment is made to the distant site consulting physician regardless of specialty (e.g., neurologist versus neurosurgeon). The originating site hospital receives a small payment to cover its costs for the telemedicine services (approximately \$27 in CY 2019).

The *ACCESS Telemedicine* model proposes an alternative: a bundled payment for Medicare patients with neurological conditions requiring emergency care. Under the *ACCESS Telemedicine* proposal, a hospital that serves as the originating site would receive a bundled payment when using neurology or neurosurgery telehealth consults from distant site practitioners. The bundled payment is designed to cover the cost of the consultation by a physician, the cost of the technology to enable the remote physician to communicate with the facility where the patient is located, the cost the entity providing the consultation services incurs for ensuring provider availability, the provision of education to local staff, and quality assurance. Under the proposal, the originating site hospital would bill for and receive the payment from Medicare, and that hospital would then be responsible for paying the entity that provides access to the distant site neurologist or neurosurgeon and the telemedicine technology. The *ACCESS Telemedicine* program currently uses the Net Medical Express (NMXS) platform to provide the audiovisual technology, call center, and network infrastructure to connect remote hospitals to neurologists and neurosurgeons. The proposal notes that other providers besides NMXS could develop and offer this service.

In contrast to current Medicare payment methodology, which pays the same amount for a specific service regardless of the specialty of the physician who is providing that service, the proposed *ACCESS Telemedicine* program payments would differ by the consulting provider specialty. The total payment per consult is proposed to be \$850 for neurology and \$1,200 for neurosurgery. Submitter documents describe the use of a “fair market value” approach to determine the per consult payment to the consulting physician (\$250 for neurology, \$400 for neurosurgery). An amount of \$175 per consult regardless of specialty is included in the bundled payment to cover the technology platform. Finally, the remainder of the payment (which differs by specialty: \$425 for neurology, \$625 for neurosurgery) is intended to cover other program components, including an on-call payment for neurosurgeon support (\$100 per day) and other

educational and administrative support costs to deliver the *ACCESS Telemedicine* services. Table 1 summarizes these amounts.

**Table 1: UNMHSC Proposed Payments by Provider Type**

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

The proposal and additional information provided by the submitter indicate that this payment approach would cover the costs of consultation services that enable reductions in unnecessary transfer of patients and more timely initiation of treatment for patients who can be appropriately cared for at the originating facility. Quality of care is addressed at multiple points, including originating hospital approval of consulting provider credentials, monthly review for quality by ACCESS clinical staff of all stroke cases and one-third of other cases, and targeted clinical education for staff at the originating facilities. By increasing access to care in their own community for patients who do not need to be transferred, the proposed *ACCESS Telemedicine* model also enables patient choice.

The ACCESS program experienced challenges enrolling hospitals during the time period it was supported by HCIA funds, and as a result, the HCIA evaluator determined there were too few Medicare and Medicaid treatment beneficiaries to conduct a rigorous impact analysis. However, the HCIA evaluation reported anecdotal evidence from originating hospital and UNM staff that ACCESS patients received tissue plasminogen activator (tPA) more often and sooner because of the telehealth consultations. In cases of ischemic stroke where using tPA to dissolve blood clots is appropriate, guidelines recommend administration within three hours.<sup>1</sup> The use of clot-dissolving drugs such as tPA is time-sensitive and carries a risk of excessive bleeding; thus, timely and accurate assessment for the appropriate administration and monitoring is very important. Cost modeling published by the submitter appears to use these data on timely tPA administration in its estimate that *ACCESS Telemedicine* may save \$4,241 per patient in health

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<sup>1</sup> *Target: Stroke Campaign Manual: Time Lost Is Brain Lost*. American Heart Association/American Stroke Association; 2010. [http://www.strokeassociation.org/idc/groups/heart-public/@wcm/@hcm/@gwtg/documents/downloadable/ucm\\_308277.pdf](http://www.strokeassociation.org/idc/groups/heart-public/@wcm/@hcm/@gwtg/documents/downloadable/ucm_308277.pdf)



care utilization costs in the 90 days post event.<sup>2</sup> Subsequent unpublished cost analyses from the submitter extend these results for ischemic stroke to the first year and lifetime after the event, estimating \$13,617 and \$35,761 in savings per patient, respectively.

## **RECOMMENDATION AND COMMENTS TO THE SECRETARY**

PTAC recommends the *ACCESS Telemedicine* proposal to the Secretary for further development and implementation as a payment model, as specified in the comments below. PTAC believes that the proposal takes a big step toward addressing the genuine problem of limited access to specialist care in rural areas for patients with emergency neurological conditions. The Committee believes that the proposed model would reduce duplication of resources and unnecessary transfers under the current health care system and help transition to a system that uses new technology to provide appropriate, high-quality care as quickly as possible.

The Committee feels that a strength of the proposal is the central role of health information technology. The technology combines remote specialist consultations via videoconferencing and sharing of medical test results (e.g., imaging) and integrates with multiple electronic health record (EHR) systems. This capability is expected to give remote specialist consultants access to the information required for the consult without requiring the specialists to have access to each originating hospital's EHR system. The telemedicine platform provides a telemedicine cart with components to enable the videoconference that minimizes the sourcing and training requirements for the originating hospital.

Further, PTAC believes the proposed *ACCESS Telemedicine* model has the potential to improve quality and outcomes for patients while reducing spending for Medicare, and patients and families by reducing unnecessary transfers. Eliminating unnecessary transfers would also reduce the burden on patients to travel long distances for care when local care is sufficient. By enabling more patients to receive care locally, the model may contribute to the financial viability of rural and community hospitals that are then able to keep the revenue associated with providing care to those patients.

Committee members find that the proposed *ACCESS Telemedicine* model offers a simple and clearly defined payment structure with a single bundled amount. The bundle is intended to cover the full cost of the services, including the telehealth consultation, technology costs, on-call availability for neurosurgeons, staff education, data collection, and quality assurance. While the payment model is well specified, the Committee feels several components should be revised or refined before implementation.

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

The Committee notes that the proposed payment model departs from current Medicare FFS payment policy in paying different amounts based on provider specialty, with neurosurgical consults being paid at a higher rate than neurological consults. Payment amounts also include monies for items not historically paid by Medicare FFS, including on-call availability, technology platform, and infrastructure costs, and so it will be necessary to have a way to ensure that the amounts included in the payment for these costs are appropriate.

Unlike existing telemedicine payment and other services paid for through Medicare FFS, payment under the proposed *ACCESS Telemedicine* bundle would be made to the rural hospital, not the consultation provider, and the rural hospital would then be responsible for making payment to the technology platform service and the consulting provider at the distant site. PTAC members believe that it is unlikely the rural hospital would have access to the data required to monitor and report on quality and costs, and it would be inefficient for the hospital to try to do so given the low volume of consults at each individual facility. Consequently, PTAC believes further consideration of the appropriate alternative payment model (APM) entity is warranted.

In addition, PTAC discussed alternative approaches to ensuring quality, including originating hospital review of consulting provider credentials, relying on certification as a stroke center or other appropriate accreditation, or designating specific entities as qualified to deliver and bill for the consultation services, similar to the way some payers have designated providers as “centers of excellence.”

As designed, the proposed *ACCESS Telemedicine* bundle is limited to the telemedicine services and associated technology, on-call availability, education, and training costs, within a 24-hour period. As part of further development, PTAC suggests considering a broader set of services to be included in the bundle. Committee members suggest considering the incorporation of transportation, imaging and radiology, and/or other costs related to the episode of care (e.g., hospitalist services, medication, or care beyond the first 24 hours) into the bundle. The submitter noted at the public meeting that expansion of the services covered in the episode bundle would provide an opportunity to embed risk sharing into the proposed model.

The Committee believes that additional economic modeling is needed to set appropriate payment amounts for the Medicare program, specifically the fair market value approach and volume assumptions for fixed cost elements of the payment. Modifications may also be needed in order to use the model for Critical Access Hospitals, since they receive cost-based reimbursement for services, and potentially for other kinds of providers.

PTAC also suggests clarifying and potentially narrowing the conditions and diagnosis codes that would be eligible for the bundle. Although patients with a broad range of neurological conditions could likely benefit from these consultations, overuse could occur if the service is used for conditions that are not efficiently addressed by this intervention.

Committee members also expressed interest in considering expanding the model to other specialties beyond neurology and to other types of facilities. Facilities other than rural hospitals may lack round-the-clock sub-specialty expertise and could benefit from access to providers with this training through a program like *ACCESS Telemedicine*.

Finally, the Committee noted that state licensing and credentialing requirements of both hospitals and payers may present barriers to scaling the model across jurisdictions. Efforts to reduce these barriers may be needed in order for the proposed model to be successful.

## EVALUATION OF PROPOSAL USING SECRETARY’S CRITERIA

### PTAC Rating of Proposal by Secretarial Criteria

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

#### Criterion 1. Scope (High-Priority Criterion)

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

**Rating: Meets and Deserves Priority Consideration**

PTAC concludes that the proposed model meets this criterion and deserves priority consideration. The proposal aims to improve access to neurological emergency care among Medicare FFS beneficiaries in rural areas, where neurology workforce shortages challenge the ability of hospitals to care for such patients. The model would strengthen the capacity of rural

hospitals or other facilities without sophisticated neurological services to provide neurological emergency care by increasing access to physician specialists at distant sites through telemedicine.

The model would also build the knowledge and confidence of originating site hospital staff in providing care for neurological emergencies through training, education, and outreach. According to the submitter, this continuing education and outreach is key to keeping rural providers engaged and comfortable with using the services in the face of low patient volume and high staff turnover in rural facilities.

The model seeks to mitigate existing telemedicine implementation challenges for rural and community facilities. Some teleneurology programs in the United States (not paid for directly by Medicare FFS) require a significant upfront investment or payment by the rural hospital and/or charge a maintenance fee or annual subscription. The proposed model would require minimal upfront investment to participate and would charge on a per use basis.

By allowing originating hospitals to care for more neurological emergencies locally and to be reimbursed for these services, the proposed model would enable access to care and increase the financial viability of these hospitals. This approach could help preserve existing hospitals in rural areas and avoid further erosion of access to care. Further, the proposed model enables facilities to offer 24/7 coverage for neurological emergency services, something that is currently beyond the financial or technical capabilities of some facilities, including rural hospitals.

## Criterion 2. Quality and Cost (High-Priority Criterion)

*Are anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.*

### Rating: Meets and Deserves Priority Consideration

The proposed model meets this criterion and deserves priority consideration. The *ACCESS Telemedicine* program is intended to improve quality of care for Medicare FFS beneficiaries who experience cerebral emergencies in rural areas by enhancing the capacity of their local providers to deliver medically appropriate care. By giving these providers access to neurological expertise for serving patients presenting with neurological emergencies (e.g., head injuries and suspected strokes), *ACCESS Telemedicine* would reduce the need to transfer some patients to facilities with neurologists for evaluation and treatment and enable local providers to be more confident in directly admitting patients they can care for appropriately. The model also aims to decrease costs, including those associated with unnecessary transfers.

Unpublished data provided by the submitter maintain that its model reduced transfers out of rural facilities from 90 percent before *ACCESS Telemedicine* implementation to 15 percent after implementation. Reduced transfers not only lower expenditures on transportation services but

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

### Criterion 3. Payment Methodology (High-Priority Criterion)

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

#### Rating: Meets

The proposed model meets this criterion. The Committee agrees that changes in current payment systems are needed in order to support specialty consultations for emergency conditions in rural hospitals. *ACCESS Telemedicine* offers a simple and clearly defined payment structure with a single bundled amount designed to cover the full set of physician consultation, technology, on-call availability for neurosurgeons, staff education, data collection, and quality assurance.

The Committee notes that the proposed payment model departs from current Medicare FFS payment policy in paying different amounts based on provider specialty, with neurosurgical consults being paid at a higher rate than neurological consults. Payment amounts also include monies for items not historically paid by Medicare FFS, including on-call availability, technology platform, and infrastructure costs, and so it will be necessary to have a way to ensure that the amounts included in the payment for these costs are appropriate.

Unlike existing telemedicine payment and other services paid for through Medicare FFS, payment under the proposed *ACCESS Telemedicine* bundle would be made to the rural hospital, not the consultation provider, and the rural hospital would then be responsible for making payment to the technology platform service and the consulting provider at the distant site. This approach would not enable Medicare to ensure directly that the services being delivered for the payment were of high quality or to ensure that the payment was adequate but not excessive for the services being delivered. In contrast, this arrangement could be done if the payment was made directly to the consultation provider following a consultation that had been requested by a rural hospital. PTAC members believe that it is unlikely the rural hospital would

have access to the data required to monitor and report on quality and costs, and it would be inefficient for the hospital to try to do so given the low volume of consults at each individual facility. Consequently, PTAC believes further consideration of the appropriate APM entity is warranted.

In addition, PTAC discussed alternative approaches to ensuring quality, including originating hospital review of consulting provider credentials, relying on certification as a stroke center or other appropriate accreditation, or designating specific entities as qualified to deliver and bill for the consultation services, similar to the way some payers have designated providers as “centers of excellence.”

As designed, the proposed *ACCESS Telemedicine* bundle is limited to the telemedicine services and associated technology, on-call availability, education, and training costs, within a 24-hour period. As part of further development, PTAC suggests considering a broader set of services to be included in the bundle. Committee members suggest considering the incorporation of transportation, imaging and radiology, and/or other costs related to the episode of care (e.g., hospitalist services, medication, or care beyond the first 24 hours) into the bundle. The submitter noted at the public meeting that expansion of the services covered in the episode bundle would provide an opportunity to embed risk sharing into the proposed model.

Some members briefly discussed whether it would be possible to achieve the model’s goals through changes in the fee schedule, though the proposed payment is to the originating hospital rather than a physician. While the submitter proposed that the originating hospital should be the APM entity as it retains decision-making for patient care, the Committee notes that this arrangement would be unusual. As indicated earlier, under current Medicare provisions, the physician providing a telemedicine consult bills Medicare directly for their services. Thus, the originating hospital serving as the APM entity and passing payment along to the consulting provider would be a departure from current Medicare FFS payment policy.

Finally, the Committee believes that additional economic modeling is needed to set appropriate payment amounts for the Medicare program, specifically the fair market value approach and volume assumptions for fixed cost elements of the payment. Modifications may also be needed in order to use the model for Critical Access Hospitals, since they receive cost-based reimbursement for services, and potentially for other kinds of providers.

#### Criterion 4. Value over Volume

*Provide incentives to practitioners to deliver high-quality health care.*

**Rating: Meets**

The proposed model meets this criterion. As noted under the prior criteria, this program would enable providers to deliver high-quality health care, either in the originating site or by ensuring

appropriateness of transfer for cases needing more advanced neurological care or neurosurgical resources. The proposal seeks to reduce unnecessary transfers to tertiary care facilities and enable local providers to care for patients when appropriate.

The submitter indicated that the education provided through the *ACCESS Telemedicine* program has resulted in greater comfort and confidence among hospitalists in providing care for neurology patients and therefore has reduced transfers to distant facilities. By providing medically appropriate care to patients who do not require transfer, rural and community hospitals can increase the volume of patients they care for locally, strengthening the hospitals' financial viability. The proposed model relies on new technology to avoid inefficient duplication of services while expanding access despite constraints in the supply of neurologists and neurosurgeons.

### Criterion 5. Flexibility

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

#### Rating: Meets

The proposed model meets this criterion. PTAC finds that the proposed program is highly flexible and adds treatment options without imposing new constraints. The proposed *ACCESS Telemedicine* model allows flexibility to provide care in local settings rather than transferring cases out to distant facilities. The physician at the originating site retains treatment decision-making, with the consulting neurologist or neurosurgeon making recommendations only.

The criteria for seeking a consultation under the model are flexible. Physicians can request a consult for any neurological condition, not just strokes as in many telestroke programs. Although this flexibility is valuable, PTAC notes the potential for overuse of the service if the criteria for consults are not specific to prevent providers from requesting consults for too broad a range of conditions.

The proposed model allows originating sites to retain their existing transfer relationships, and it does not incentivize or expect transfers to go to the consulting physician's facility. Further, remote specialists providing telemedicine consults can be based anywhere rather than being limited to a particular hospital or health system, which may increase the pool of available consulting physicians. However, individual state licensing and credentialing requirements of hospitals and payers may present a barrier to scaling the proposed model across jurisdictions. The current *ACCESS Telemedicine* program relies on NMXS to coordinate hospital credentialing and New Mexico licensure for specialists. According to the submitter, the credentialing process requires a fair amount of time and investment in administrative staff. There is no uniform credentialing process across hospitals, nor a national standard for telemedicine licensure. The capacity of NMXS to support national scaling of the proposed *ACCESS Telemedicine* model, as

well as feasibility of depending on other vendors for this support, should be considered in the development of the payment model.

## Criterion 6. Ability to Be Evaluated

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

### Rating: Meets

The proposed model meets this criterion. The submitter proposes quality measures and evaluation approaches in areas including patient experience, total cost of care, readmissions, transfer rates, and timeliness of care (e.g., imaging, tPA administration). Implementation of the payment model should include consideration of how measures could be created to evaluate long-term costs and benefits.

The *ACCESS Telemedicine* quality assurance component includes collection and analysis of data on quality and timeliness of care. These data are reviewed for all stroke cases and one-third of other consults. While the submitter outlines possible quality measures, the Committee raises concerns about the ability of the originating site hospital, as the APM entity, to track and report on these measures, given the low volume of consults at each facility. PTAC also identifies attention to quality measures and monitoring as priorities in further development of the payment model.

## Criterion 7. Integration and Care Coordination

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

### Rating: Meets

The proposed model meets this criterion. PTAC finds that an underlying goal of the program is to improve integration and care coordination. The proposed model attempts to improve coordination between different care settings, primarily rural hospitals and tertiary care facilities.

In the *ACCESS Telemedicine* proposal, the consulting specialist relies on the audiovisual patient examination, information provided by the rural physician, and imaging or lab results shared via cloud technology. However, the consulting specialist does not have direct access to information in the patient EHR that may inform diagnostic and/or treatment recommendations.



## Criterion 8. Patient Choice

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

### Rating: Meets

The proposed model meets this criterion. *ACCESS Telemedicine* is intended to support the needs and preferences of individual patients within a framework based on access to high-quality expertise. By reducing avoidable transfers, the proposed model would allow more patients to receive care in their local community, which may align with patient and family preferences.

As described by the submitter, the proposed model allows for patient and family member involvement in decision-making to the extent the patient is able to participate. Before participating in a telemedicine consult, patients provide informed consent (or an appropriate health care proxy consent if the patient is not able to provide consent). Family member involvement is a strength of the approach since patient choice may be less relevant given the potential cognitive impairment of a patient experiencing a neurological emergency. Consultations through *ACCESS Telemedicine* can also help identify cases where further care would be futile, thereby enabling providers, and patients and families to choose palliative or non-invasive approaches when appropriate.

## Criterion 9. Patient Safety

*Aim to maintain or improve standards of patient safety.*

### Rating: Meets

The proposed model meets this criterion. *ACCESS Telemedicine* aims to strengthen providers' capacity to provide care for patients presenting with neurological emergencies locally through learning from the consulting specialists, as well as the training, education, and clinical support provided through the program. The proposal also acknowledges recognized standards for patient safety that would be followed, and emphasizes the importance of evidence-based care.

## Criterion 10. Health Information Technology

*Encourage use of health information technology to inform care.*

### Rating: Meets and Deserves Priority Consideration

The proposed model meets this criterion and deserves priority consideration. The proposed model relies on telemedicine technology to provide neurological emergency care in settings that lack adequate neurologist or neurosurgeon access. The technology combines remote

specialist consultations via videoconferencing, sharing of medical test results (e.g., imaging), and integration with multiple EHR systems. This technology gives remote specialist consultants access to the information required for the consult without requiring the specialists to have access to each originating hospital's EHR system. Altogether, this technology solution enables providers in rural areas to have rapid access to expertise not available in their communities.

The submitter currently relies on a third-party company, NMXS, for the telemedicine platform and connection to remote physician specialists. NMXS reports successfully integrating with multiple EHR systems including Epic, Allscripts, NextGen, NovaScan and many other smaller EHRs. However, the submitter states that this arrangement is flexible, and NMXS in its public comment indicated a willingness to license the technology to others. Interoperability of health information technology across different institutions and with telemedicine platform vendors outside of NMXS could be challenging.

## **APPENDIX 1. COMMITTEE MEMBERS AND TERMS**

**Jeffrey Bailet, MD, Chair**

**Grace Terrell, MD, MMM, Vice Chair**

### Term Expires October 2019

**Tim Ferris, MD, MPH**

*Massachusetts General Physicians  
Organization*

Boston, MA

### Term Expires October 2020

**Rhonda M. Medows, MD**

*Providence St. Joseph Health  
Seattle, WA*

**Harold D. Miller**

*Center for Healthcare Quality and Payment Reform  
Pittsburgh, PA*

**Len M. Nichols, PhD**

*Center for Health Policy Research  
and Ethics*

*George Mason University  
Fairfax, VA*

**Grace Terrell, MD, MMM**

*Eventus WholeHealth  
Concord, NC*

### Term Expires October 2021

**Jeffrey Bailet, MD**

*Altais  
San Francisco, CA*

**Kavita Patel, MD, MSHS**

*Johns Hopkins Health System  
Baltimore, MD*

**Angelo Sinopoli, MD**

*Prisma Health  
Greenville, SC*

**Jennifer Wiler, MD, MBA**

*University of Colorado School of  
Medicine  
Aurora, CO*

### Term Expires October 2022

**Paul N. Casale, MD, MPH**

*New York Quality Care  
New York-Presbyterian, Columbia University College of  
Physicians and Surgeons, Weill Cornell Medicine  
New York, NY*

**Bruce Steinwald, MBA**

*Independent Consultant  
Washington, DC*

## APPENDIX 2. PFPM CRITERIA ESTABLISHED BY THE SECRETARY

### PFPM CRITERIA ESTABLISHED BY THE SECRETARY

- 1. Scope.** Aim to either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM Entities whose opportunities to participate in APMs have been limited.
- 2. Quality and Cost.** Are anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.
- 3. Payment Methodology.** Pay APM Entities with a payment methodology designed to achieve the goals of the PFPM criteria. Addresses in detail through this methodology how Medicare and other payers, if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the PFPM cannot be tested under current payment methodologies.
- 4. Value over Volume.** Provide incentives to practitioners to deliver high-quality health care.
- 5. Flexibility.** Provide the flexibility needed for practitioners to deliver high-quality health care.
- 6. Ability to Be Evaluated.** Have evaluable goals for quality of care, cost, and any other goals of the PFPM.
- 7. Integration and Care Coordination.** Encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM.
- 8. Patient Choice.** Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.
- 9. Patient Safety.** Aim to maintain or improve standards of patient safety.
- 10. Health Information Technology.** Encourage use of health information technology to inform care.

**APPENDIX 3. DISTRIBUTION OF MEMBER VOTES ON EXTENT TO WHICH PROPOSAL MEETS CRITERIA**

Criteria Specified by the Secretary (at 42 CFR §414.1465)	Not Applicable	Does Not Meet Criterion		Meets Criterion		Priority Consideration		Rating
	*	1	2	3	4	5	6	
1. Scope (High Priority) <sup>3</sup>	0	0	0	1	3	3	4	Meets and Deserves Priority Consideration
2. Quality and Cost (High Priority)	0	0	0	2	3	5	1	Meets and Deserves Priority Consideration
3. Payment Methodology (High Priority)	0	1	0	7	3	0	0	Meets Criterion
4. Value over Volume	0	0	0	3	4	4	0	Meets Criterion
5. Flexibility	0	0	0	2	7	2	0	Meets Criterion
6. Ability to Be Evaluated	0	0	0	3	7	1	0	Meets Criterion
7. Integration and Care Coordination	0	0	1	0	5	3	2	Meets Criterion
8. Patient Choice	0	0	0	0	6	5	0	Meets Criterion
9. Patient Safety	0	0	0	0	6	3	2	Meets Criterion
10. Health Information Technology	0	0	0	2	3	2	4	Meets and Deserves Priority Consideration

<sup>3</sup>Criteria designated as “high priority” are those PTAC believes are of greatest importance in the overall review of the payment model proposal.

## APPENDIX 4. DISTRIBUTION OF MEMBER VOTES ON OVERALL RECOMMENDATION

### Overall Recommendation Vote: Part 1 of 2<sup>4</sup>

Not Recommended for Implementation as a PFPM	Recommended	Referred for Other Attention by HHS	Result
0	11	0	Recommended

### Overall Recommendation Vote: Part 2 of 2 (if applicable)

Proposal substantially meets Secretary's criteria for PFPs. PTAC recommends implementing proposal as a payment model.	PTAC recommends further developing and implementing the proposal as a payment model as specified in PTAC comments.	PTAC recommends testing the proposal as specified in PTAC comments to inform payment model development.	PTAC recommends implementing the proposal as part of an existing or planned CMMI model.	Result
2	9	0	0	PTAC recommends further developing and implementing the proposal as a payment model as specified in PTAC comments.

**Final recommendation to Secretary: PTAC recommends further developing and implementing the proposal as a payment model as specified in PTAC comments.**

<sup>4</sup> In 2018, PTAC adopted new voting categories, used first at its December 2018 public meeting. First, PTAC votes on the three categories listed above as Part 1 of 2. PTAC must achieve a two-thirds majority for one of these categories. If a two-thirds majority votes to not recommend the proposal for implementation as a PFPM or to refer the proposal for other attention by HHS, that category is the Committee's final recommendation to the Secretary. If the two-thirds majority votes to recommend the proposal, the Committee proceeds to Part 2 of 2 to determine the final, overall recommendation for the Secretary. The second vote uses the four subcategories listed above. A two-thirds majority must be achieved for one of these four categories.