

PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL  
ADVISORY COMMITTEE (PTAC)

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PUBLIC MEETING

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Virtual Meeting Via Webex

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Wednesday, September 16, 2020

PTAC MEMBERS PRESENT

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

PTAC MEMBERS IN PARTIAL ATTENDANCE

JOSHUA M. LIAO, MD, MSc

PTAC MEMBERS NOT IN ATTENDANCE

KAVITA PATEL, MD, MSHS

STAFF PRESENT

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

CONTRACTOR STAFF PRESENT

ADIL MOIDUDDIN, NORC at the University of Chicago

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

2 10:00 a.m.

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

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

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

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

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

1 perspectives on telehealth and Alternative  
2 Payment Models.

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

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

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

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

22 As the Committee has reviewed the

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

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

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

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

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

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

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

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

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

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

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

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

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

10           If you've not registered in advance to  
11 give an oral public comment, but would like to,  
12 please email [ptacregistration@norc.org](mailto:ptacregistration@norc.org). Again,  
13 that's [ptacregistration@norc.org](mailto:ptacregistration@norc.org).

14           We also encourage stakeholders to  
15 submit public comments on telehealth by emailing  
16 them to [ptac@hhs.gov](mailto:ptac@hhs.gov).

17           Again, you are welcome to submit  
18 public comments about telehealth in writing to  
19 [ptac@hhs.gov](mailto:ptac@hhs.gov). We intend to post any written  
20 public input we receive online.

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

1 thoughts on the day's events before adjourning.

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

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

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

1 delivery model within them and interviewed the  
2 submitters.

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

7 Adil.

8 \* **Overview of PTAC Proposals with**  
9 **Telehealth Components Presentation**

10 MR. MOIDUDDIN: Thank you, Dr. Bailet.

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

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

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

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

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

6 This presentation summarizes the  
7 characteristics of these models taken from an  
8 environmental scan on the topic of telehealth in  
9 the context of APM<sup>1</sup>s commissioned by PTAC that can  
10 be accessed on the ASPE PTAC website at the URL  
11 listed.

12 This work uses the definition of  
13 "telehealth" used by the Office of<sup>2</sup> the  
14 Advancement of Telehealth at the Health Resources  
15 and Services Administration, mainly, the use of  
16 electronic information and telecommunication  
17 technologies to support long-distance clinical  
18 health care; patient and professional health-  
19 related education; public health and health  
20 administration.

21 It includes telehealth services

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1 Alternative Payment Model (APM)

2 Office for the Advancement of Telehealth

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

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

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

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

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

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

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

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

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

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

22           If you're interested in diving into

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

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

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

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

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

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

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

12 The Committee's remarks emphasize  
13 data-sharing opportunities created by health IT  
14 and telehealth; noted opportunities to use  
15 telehealth to create efficiencies for providers;  
16 and highlighted use of telehealth to support  
17 higher quality of care, enable earlier  
18 intervention, and finally, support reductions in  
19 ED<sup>3</sup> visits, hospitalizations and mortality.

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

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3 Emergency Department (ED)

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

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

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

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

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

22 I want to note one last time that this

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

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

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

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

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

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

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

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

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

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

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

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

21           (Pause.)

22           CHAIR BAILET: Barbara, you're on mute.

1 (Pause.)

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

4 DR. MCANENY: It keeps muting me again.

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

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

10 CHAIR BAILET: Alright.

11 DR. MCANENY: So I'm Barbara McAneny.

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

16 And this built off the previous CMMI<sup>4</sup>  
17 award I had had in 2012 called Come Home for  
18 Community Oncology Medical Home where we  
19 estimated a savings of about \$600 per patient, in  
20 cancer patients, by early intervention to keep  
21 them out of the hospital by managing the side

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4 Center for Medicare and Medicaid Innovation (CMMI)

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

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

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

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

22 So when we started this, telemedicine,

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

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

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

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

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

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

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

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

17           CHAIR BAILET: Thank you, Barbara.

18           Next, we have Heidy.

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

1           In 2018, the AAFP<sup>5</sup> submitted the  
2           Advanced Primary Care Alternative Payment Model  
3           for PTAC's consideration. In regarding that, our  
4           model, it had four distinct payment mechanisms.

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

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

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

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

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

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5 American Academy of Family Physicians (AAFP)

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

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

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

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

22 So we believe that technology used to

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

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

10 CHAIR BAILLET: Thank you, Heidy.

11 Stetson Berg?

12 MR. BERG: Good morning, everyone.

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

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

1 different rural sites.

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

5 CHAIR BAILLET: Thank you, Stetson.

6 Jeffrey Davis?

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

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

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

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

22 Emergency physicians in the model

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

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

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

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

1 facility.

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

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

12 CHAIR BAILET: You bet. Thanks,  
13 Jeffrey.

14 Larry?

15 (Pause.)

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

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

20 Can you hear me? Can you hear me?

21 CHAIR BAILET: Yes, we can.

22 DR. KOSINSKI: Okay. Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

1 can be then correlated with changes in  
2 utilization in cost.

3 The deployment of the Sonar platform  
4 has consistently resulted in significant --  
5 statistically significant savings in total cost  
6 driven by an equally statistically significant  
7 decline in hospitalizations, ER<sup>6</sup> visits, and  
8 outpatient care. Thank you.

9 CHAIR BAILET: Thanks, Larry.

10 Last, we have David.

11 DR. BASEL: Alright. Thank you, Chair.

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

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

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6 Emergency Room (ER)

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

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

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

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

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

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

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

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

11 CHAIR BAILET: Great. Thanks, David.

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

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

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

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

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

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

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

1 thoughts together, but go ahead, Barbara.

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

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

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

22 We also recognize that if our patients

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

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

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

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

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

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

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

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

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

19 CHAIR BAILET: Nice job, Barbara.

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

1 questions.

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

5 DR. MCANENY: Thank you.

6 CHAIR BAILET: Let's talk with Heidy.

7 MS. ROBERTSON-COOPER: Great.

8 So for the first question around how  
9 might anything that we submitted facilitate or  
10 help with the lessons or more broadly based on  
11 the PHE<sup>7</sup>.

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

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

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7 Public Health Emergency (PHE)

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

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

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

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

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

22 So regarding the second question as it

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

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

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

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

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

22 So a primary care payment model that

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

4 CHAIR BAILET: Thanks, Heidy.  
5 Stetson?

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

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

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

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

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

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

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

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

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

22 As many of you know, New Mexico is a

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

5 And then also supporting the focus of  
6 the rural facilities on continuing education that  
7 we've been providing, which has been increasing  
8 the local competency and fostered resilience for  
9 those health systems. And I know, for example,  
10 tPA<sup>8</sup> administration went up, I think, 20 times  
11 during our model.

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

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

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

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8 tissue plasminogen activator (tPA)

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

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

13 CHAIR BAILET: Thanks, Stetson.

14 Jeffrey?

15 MR. DAVIS: Great.

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

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

1       restrictions.

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

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

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

22                   So I think we have to think more

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

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

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

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

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9 Emergency Medical Services (EMS)

10 Emergency Triage, Treat and Transport (ET3)

1 again, can lead to more innovative questions.

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

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

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

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

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

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

9 CHAIR BAILET: Thank you, Jeffrey.

10 Larry?

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

15 When we presented our PFFM back in  
16 2017, we had already documented the fact that  
17 patients with symptomatic chronic disease accept  
18 their symptoms as variants of normal. As a  
19 result, they typically do not seek medical care  
20 early enough to avoid morbidity.

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

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

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

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

12               To correct this and produce resilience  
13       in value-based care, telehealth must move beyond  
14       being reactive care and should be proactive  
15       engaging patients even before they realize that  
16       they need engagement. This will require changes  
17       to CPT<sup>11</sup> codes to allow for proactive care.

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

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11 Current Procedural Terminology (CPT)

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

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

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

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

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

1 ongoing payment. This has limited their  
2 acceptance.

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

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

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

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

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

22 This has enabled medical practices to

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

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

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

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

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

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

22 David?

1 DR. BASEL: Thank you, Dr. Bailet.

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

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

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

22 And so this has been such a blessing

1 to have some of those technologies in place for  
2 us.

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

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

10 And so now we've more than doubled to  
11 150 nursing homes that we are delivering services  
12 to right now, but it's not just the in-person  
13 care.

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

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

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

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

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

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

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

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

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

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

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

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

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

22 CHAIR BAILET: Thanks, David.

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

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

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

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

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

1 monitoring.

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

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

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

19 And I liked your comment about  
20 preserving PPE<sup>12</sup>. That was an angle that I  
21 certainly didn't think about that I thought was

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12 Personal Protective Equipment (PPE)

1       pretty important here.

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

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

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

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

22                      Are there any additional questions,

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

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

6 Can you hear me?

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

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

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

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

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

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

16 CHAIR BAILLET: Anybody is welcome to --  
17 David?

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

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

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

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

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

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

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

1 behavioral health people.

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

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

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

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

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

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

22 And during the pandemic, I talked to a

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

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

12 CHAIR BAILET: Thanks, Jeffrey.

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

16 So Heidy, please.

17 MS. ROBERTSON-COOPER: Alright. Thank  
18 you.

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

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

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

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

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

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

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

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

5 Lauran, your question?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 modalities.

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

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

12 CHAIR BAILET: Thanks, Barbara.

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

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

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

22 And so to have a comprehensive primary

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

6 The APM that we have proposed is an  
7 increase in primary care payment as it's  
8 currently paid today. So it's looking at 10 to  
9 12 percent of spends instead of about six percent  
10 of priority spending.

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

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

21 CHAIR BAILET: Thanks, Heidy.

22 Larry, you had one comment that you

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

3 Could you do that, please?

4 DR. KOSINSKI: Yes.

5 I would like to build upon something  
6 Heidi said. Just about every statement she made  
7 about what's happening in the primary care  
8 practice is also happening in the specialty care  
9 practice.

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

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

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

22 CHAIR BAILET: Thanks. Thanks, Larry.

1                   Jen?

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

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

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

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

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

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

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

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

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

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

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13 Health Insurance Portability and Accountability Act (HIPAA)

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

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

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

22 So we need to make sure that we use

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

5 So I think we need to very carefully  
6 embed them and recognize that if we can make it  
7 less expensive by keeping these tools at a  
8 minimal cost, if we can do accurate cost  
9 accounting, which is, frankly, the basis of  
10 MASON, to be able to say this is the cost of a  
11 15-minute visit with telemedicine with the  
12 patient, and not disadvantages the practices by  
13 paying less than the cost of delivering the  
14 service, then I think you've added another  
15 important tool to our toolkit.

16 CHAIR BAILET: Okay. Thank you,  
17 Barbara.

18 Larry, I know you had raised your  
19 hand.

20 DR. KOSINSKI: Yes. A short addition.  
21 We have been working very diligently  
22 on developing the cohort science behind getting

1 patients to respond.

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

5 Some patients are fearful of  
6 electronic transmissions and fearful of  
7 telephonic visits.

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

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

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

22 Grace, you had a question?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4                   CHAIR BAILET: Thank you.

5                   Stetson, did you want to add  
6 something?

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

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

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

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

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

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

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

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

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

5 So they obviously have on-call  
6 schedules for this, and then there's also ad hoc.  
7 And we also contract with kind of a provider pool  
8 to make sure we can get to these systems within  
9 15 minutes of a consult. So sometimes  
10 credentialing.

11 And I would say another thing that  
12 would be fantastic is that we're seeing them move  
13 towards the HIE<sup>14</sup>s.

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

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

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14 Health Information Exchange (HIE)

15 University of New Mexico (UNM)

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

7 VICE CHAIR TERRELL: Thank you.

8 CHAIR BAILET: Thanks, Stetson.

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

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

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

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

22 In addition to what's already been

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

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

8 David, I see you raising your hand.

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

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

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

22 And so anything we can do to

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

3 CHAIR BAILET: Thank you.

4 Heidy?

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

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

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

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

1 CHAIR BAILET: Thank you.

2 MR. DAVIS: This is Jeff Davis.

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

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

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

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

1 CHAIR BAILET: Okay. Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 (Laughter.)

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

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

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

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

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

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

20                 CHAIR BAILLET: Thank you, Barbara.

21                 Heidy?

22                 MS. ROBERTSON-COOPER: Okay. So when

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

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

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

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

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

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

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

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

12           CHAIR BAILET: Thanks, Heidy.  
13           Stetson?

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

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

1 general, for the University of New Mexico.

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

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

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

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

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

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

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

11 CHAIR BAILET: Thanks, Stetson.

12 Jeffrey?

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

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

22 The ability to provide care to

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

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

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

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

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

22 There's just so much potential in

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

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

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

13 CHAIR BAILET: Awesome. Thank you,  
14 Jeffrey.

15 Larry?

16 DR. KOSINSKI: Last but not least.

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

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

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

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

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

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

17          CHAIR BAILET: Thanks, Larry.

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

22          DR. BASEL: Thank you, Chair.

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

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

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

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

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

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

8 My day job, I'm medical director of  
9 multiple ACOs<sup>16</sup>, both commercial and public,  
10 including a moderately large ENHANCED track MSSP<sup>17</sup>  
11 ACO.

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

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

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16 Accountable Care Organization (ACO)

17 Medicare Shared Savings Program (MSSP)

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

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

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

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

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

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

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

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

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

12 When would you like people to  
13 reconvene?

14 MS. AMERSON: 11:45 Eastern.

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

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

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

1 11:51 a.m.)

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

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

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

11 \* **Panel Discussion with Subject Matter**  
12 **Experts**

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

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

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

1 to respond.

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

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

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

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

19 So Anne Tumlinson, please.

20 MS. TUMLINSON: Hi. Thank you very  
21 much.

22 My name is Anne Tumlinson. I am the

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

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

8 VICE CHAIR TERRELL: Thank you, Anne.  
9 Sophia Tripoli.

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

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

19 VICE CHAIR TERRELL: Thank you,  
20 Sophia.

21 Dr. Lee Schwamm.

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

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

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

11 So very excited to be here. Thank  
12 you.

13 VICE CHAIR TERRELL: Thank you, Dr.  
14 Schwamm.

15 Dr. Lewis Levy.

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

19 My own background is practicing  
20 general medicine in the Boston area for the past  
21 32 years and teaching over at Harvard Medical  
22 School.

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

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

7 VICE CHAIR TERRELL: Thank you, Dr.  
8 Levy.

9 Dr. Chad Ellimoottil.

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

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

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

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

1 practice providers and physicians.

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

11 VICE CHAIR TERRELL: Thank you, sir.

12 Dr. Sanjeev Arora.

13 DR. ARORA: Thank you for this  
14 opportunity.

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

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

22 We are a hub-and-spoke network and

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

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

7 VICE CHAIR TERRELL: Thank you.

8 And finally, Dr. Chuck Zonfa.

9 (Pause.)

10 CHAIR BAILLET: I don't see him, Grace.

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

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

18 (Pause.)

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

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

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

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

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

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

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

1 payer, and so on?

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

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

10 MS. TRIPOLI: Thank you very much.

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

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

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

1 losses of health care coverage.

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

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

22 We've also seen how the COVID-19

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

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

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

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

22 Not only has this type of work exposed

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

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

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

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

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

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

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

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

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

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

22 Primary care practices have seen a

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

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

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

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

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

1 backstop when utilization drops.

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

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

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

1 emergency.

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

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

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

1 the pandemic.

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

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

19           VICE CHAIR TERRELL: Thank you, Sophia.  
20 Anne.

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

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

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

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

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

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

1       dressing, eating.

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

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

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

22                   So we know that issue is out there.

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

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

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

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

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

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

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

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

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

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

22 They are interdisciplinary teams.

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

4 Think of the PACE<sup>18</sup> model. Think of  
5 some of the enhanced primary care models that we  
6 don't hear about all the time, you know.

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

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

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

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

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

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

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

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

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

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

3                   DR. SCHWAMM: Great. Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22                   Those individuals really benefitted

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

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

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

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

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

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

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

11           VICE CHAIR TERRELL: Thank you, Lee.

12           I'm going to move to Chad now.

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

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

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

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

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

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

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

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

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

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

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

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

9           So we had a study by some colleagues  
10          that did a national poll of patients that were  
11          individuals that were age 50 to 80 in June, and  
12          two-thirds of them felt that telehealth care  
13          wasn't equivalent to in-person care. And about  
14          45 percent of those felt the personal connection  
15          with their provider wasn't the same.

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

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

1 70 was done through audio.

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

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

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

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

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

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

10           VICE CHAIR TERRELL: Thank you.

11           Sanjeev?

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

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

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

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

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

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

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

19                   And New Mexico, at that time, had  
20 28,000 patients with Hepatitis C and hundreds of  
21 patients were dying every year for lack of access  
22 for treatment, and that's why I started Project

1 ECHO.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22           When COVID-19 came along, our

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

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

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

20 VICE CHAIR TERRELL: Thank you.

21 Lewis?

22 DR. LEVY: Thanks so much.

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

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

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

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

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

1 seeing in the mental health arena.

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

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

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

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

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

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

4           I would also like to draw attention to  
5 the recently released findings from the NCQA<sup>19</sup>  
6 Taskforce on Telehealth Policy, which was  
7 released this week.

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

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

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19 National Committee for Quality Assurance (NCQA)

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

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

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

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

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

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

22           In terms of what are we doing in terms

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

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

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

14 So we've been working very closely  
15 with the NCQA, the NQF<sup>20</sup> and a number of -- URAC  
16 and a number of other organizations to really  
17 ensure that as we are delivering care, we're  
18 constantly measuring the quality of care to  
19 ensure that with scale come improvements in the  
20 overall quality of care.

21 So thank you so much, Anne, and happy

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20 National Quality Forum (NQF)

1 to address any questions as they may arise.

2 VICE CHAIR TERRELL: Thank you.

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

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

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

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

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

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

1       how we're going to get everything better.

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

5                       DR. ZONFA: Thank you, Grace.

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

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

13                      One is, telehealth is a valuable tool.

14       And I think we've demonstrated that over the  
15       past few months.

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

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

1 a cultural shift.

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

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

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

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

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

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

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

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

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

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

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

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

16           And I think we followed the CMS  
17 guidance on: one, showing the value of an audio-  
18 only visit and providing reimbursement for that  
19 at the same level as a face-to-face, but we  
20 developed a task force that -- it was the COVID-  
21 19 Task Force that met daily, which involved not  
22 just the medical management team from our health

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 DR. FELDSTEIN: Thank you, Grace.

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

22 Because health care is famous for

1 developing silos and especially among  
2 freestanding telehealth companies.

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

7 DR. LEVY: Thanks, Jay.

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

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

22 So that problem with interoperability,

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

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

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

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

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

1 virtual primary care offering.

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

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

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

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

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

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

4 DR. FELDSTEIN: Thanks.

5 DR. LEVY: Sure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22           And if they have predictability and,

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

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

10               MS. TUMLINSON: Can I just add  
11       something?

12               VICE CHAIR TERRELL: Go ahead.

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

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

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

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

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

1 you know, ultimately improving care for  
2 everybody.

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

5 VICE CHAIR TERRELL: Yes. Please.

6 DR. ARORA: This is Sanjeev.

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

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

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

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

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

8 VICE CHAIR TERRELL: Sophia, did I  
9 forget you?

10 MS. TRIPOLI: Sorry, Grace.

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

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

18 MS. TRIPOLI: Thank you, Grace.

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

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

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

1 the fragmentation of care, et cetera.

2 VICE CHAIR TERRELL: Thank you.

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

7 MS. HARDIN: Thank you, Grace.

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

12 VICE CHAIR TERRELL: Thank you.

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

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

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

1 centers, are inaccessible to many patients.

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

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

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

13 So I don't think we need a new payment  
14 mechanism. We already have a payment mechanism  
15 in the RVU<sup>21</sup>-based system that recognizes care  
16 complexity or time-based billing, and we have  
17 modifiers to reflect that the care was delivered  
18 over telemedicine.

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

---

21 Relative Value Unit (RVU).

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

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

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

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

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

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

1                   Jen, go ahead.

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

6                   So I'm struck by -- thank you all for  
7 being here. It's been a phenomenal conversation.

8       What I'm struck by is the perverse incentives of  
9 our current system that is hybrid, right, this  
10 range of fee-for-service to some in-play  
11 Alternative Payment Models and the points that  
12 were brought up around some of our most fragile  
13 communities being the ones that end up having  
14 this perverse incentive to move from a virtual  
15 visit into the clinic where, depending on the  
16 payment model, it may actually be a more  
17 expensive visit depending on the arrangement.

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

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

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

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

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

22           But before we do, Chuck, do you want

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

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

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

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

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

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

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

14 VICE CHAIR TERRELL: Thank you.

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

17 Chad, do you have a comment here?

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

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

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

8 And so speaking to the disparities  
9 angle, which is what you asked about, I think  
10 that knowing -- well, first thing -- first, was  
11 when we look at how, during this pandemic,  
12 different populations used telehealth.

13 We know that there is a digital  
14 divide, but yet when we look at -- and we have  
15 access to state insurance data -- and when we  
16 looked across the state of Michigan, we see that  
17 every one of those populations, like rural versus  
18 non-rural, low-income versus higher income, you  
19 know, minority groups and so forth, what we see  
20 is that all of those groups did increase the use  
21 of telehealth during this time period, but there  
22 was a delta between those groups of interest and

1 their counterparts.

2 So there was a delta, but there wasn't  
3 any population, even populations over 80, that  
4 was significantly left behind with this adoption  
5 of telehealth.

6 So that's an important point, is that  
7 all the populations are increasing the use; it's  
8 just at a different rate.

9 And so I think having this data up  
10 front, having -- seeing what happened during the  
11 pandemic actually offers policymakers a lot of  
12 insight into what will happen over the next 12  
13 months, next 24 months, if there's no policies  
14 that are in place or interventions that are in  
15 place.

16 And so -- and that could be at the  
17 federal level or that could be at the local  
18 level.

19 So knowing that older populations have  
20 challenges with using the technology, investing  
21 at the local level, investing in community  
22 centers, buyback programs for smartphones,

1 subsidizing connected devices, everyone knows  
2 about expanding -- the programs that are out  
3 there for expanding broadband, but then those are  
4 all patient-level interventions.

5 But then also at the provider level,  
6 there's providers in those communities as well  
7 that are not adopting telehealth as much as their  
8 counterparts.

9 So you know, investing and subsidizing  
10 telehealth purchases or subscriptions to those  
11 providers in that area is going to be very  
12 important, too.

13 So those are just kind of some quick  
14 ways -- I mean, it's obviously a big topic, but  
15 the fact that everyone is talking about it is  
16 really important, and that's really the first  
17 step towards mitigating that digital divide.

18 VICE CHAIR TERRELL: Thank you, Chad.

19 So I -- just looking at the time here,  
20 I know that we've got several people from the  
21 public who are wanting to speak.

22 I'm going to give you all just that

1 one more minute now to think about the one to two  
2 sentences only that you're going to advise us as  
3 we're thinking about how we might advise the  
4 Secretary.

5 While you're thinking for a minute,  
6 let me give you my personal experience with  
7 telehealth because I think it might be  
8 insightful.

9 Typically, if we were actually  
10 deliberating on a proposal, we would all have to  
11 declare any conflicts of interest or anything  
12 else to disclose.

13 It struck me while I was listening to  
14 this, that I ought to disclose I used to be a  
15 provider for Teladoc, have done about 5,000  
16 visits in 2019 in about a 10-month period of time  
17 before COVID and before the waiver, and there  
18 were several things that I learned from that  
19 experience.

20 One of them is that it actually met  
21 the need of a lot of people -- this was typically  
22 in commercial insurance or those without

1 insurance, not Medicare or Medicaid -- who needed  
2 health care services that did not need to be  
3 provided in person, but yet they had no access.

4 And so much of it was -- it was a  
5 surprising amount of dental care need. Many  
6 minor dermatologic problems. Lots of mental  
7 health.

8 You flip that to the year 2020, and I  
9 am the CEO of a company that has 650 assisted  
10 living facilities and skilled nursing facilities  
11 in five states that we had to provide to primary  
12 care, mental health services, and some other  
13 services overnight, like everybody else, to the  
14 most vulnerable and isolated population in the  
15 country during the epidemic.

16 And that was a completely different  
17 telehealth experience to a completely different  
18 population.

19 So I, for one, am a believer that it  
20 is a solution for many things. And I've had the  
21 experience both pre- and post-COVID.

22 So I believe that gave you all time to

1 think a little bit about your answers while I  
2 went on my soliloquy.

3 And what I'm now going to do, and I  
4 will be starting with you, Sanjeev, is just give  
5 you a -- just a moment, give me one, two, or  
6 three sentences on what do you think with respect  
7 to Alternative Payment Models and telehealth that  
8 PTAC needs to advise the Secretary.

9 DR. ARORA: Thank you, Grace.

10 I think that what I'd like to say that  
11 is in addition to direct telemedicine models  
12 which are extraordinarily useful in overcoming  
13 geographic barriers to care and taking care where  
14 patients need it, we need -- we have another very  
15 major problem confronting the health system, and  
16 that is the exponential growth of new knowledge  
17 and constant change that is occurring in this  
18 knowledge.

19 So the primary care provider or any  
20 physician living in a town in the United States  
21 doesn't have the ability to keep up with that  
22 information.

1           So we have a great opportunity to use  
2           telehealth or technology-enabled collaborative  
3           learning models where people can learn from each  
4           other, where we can build the latest knowledge to  
5           the last mile of health care and then use  
6           telehealth not just as a revenue-enhancing model,  
7           but use it as a way to provide the right care at  
8           the right place at the right time.

9           And sometimes it will be telehealth,  
10          sometimes it will be direct care, but for any  
11          kind of care to occur effectively, what you need  
12          is the right knowledge at the right place at the  
13          right time.

14          Without that, no technology can solve  
15          the patient's need adequately. And for that, we  
16          need new payment models. Thank you.

17                   VICE CHAIR TERRELL: Thank you.

18                   Anne.

19                   MS. TUMLINSON: I think I'll just say  
20          what he just said.

21                   (Laughter.)

22                   MS. TUMLINSON: This is transformative,

1 without question it's very exciting, but it does  
2 require a lot of flexibility.

3 New or, like, really kind of much  
4 more, like, greater degree of courage on the part  
5 of policymakers in allowing for more flexibility  
6 and investment in both paper service and  
7 Alternative Payment Models.

8 And we have to -- the long-term care  
9 population is going to get stranded if we don't  
10 do a better job of promoting and investing in the  
11 APMs that actually support the primary care,  
12 multidisciplinary teams that serve this  
13 population.

14 Like, that -- we can't -- like,  
15 telehealth isn't the solve. It is the thing that  
16 will help the solve work in scale.

17 And so you know, like, let's -- now we  
18 know we have this tool. Let's really double down  
19 on those models that we know work and the payment  
20 systems that support them.

21 VICE CHAIR TERRELL: Thank you very  
22 much.

1                   Chuck.

2                   DR. ZONFA: So mine's going to sound  
3 pretty similar, too. I would say support models  
4 of care that provide the five guidelines for  
5 appropriate use and ensuring quality.

6                   And, most importantly, and you may  
7 have heard this before in the last comment, but  
8 support a payment model that allows flexibility.

9                   We don't want a one-size-fits-all to  
10 be blanketed across the entire population of the  
11 United States.

12                   I think that different geographies  
13 have different needs, and we have to have  
14 flexibility built in. I'll end there.

15                   VICE CHAIR TERRELL: Thank you.

16                   Lewis.

17                   DR. LEVY: Well, I think it all boils  
18 down to you never let a serious crisis go to  
19 waste.

20                   And I truly believe that right now in  
21 terms of two specific recommendations, they would  
22 really be along the lines of parity with regards

1 to reimbursement between in-person care and  
2 virtual care, and also supporting infrastructure  
3 that really facilitates integration of virtual  
4 care with in-person care to address the issues  
5 raised before around interoperability.

6 VICE CHAIR TERRELL: Thank you.

7 Lee.

8 DR. SCHWAMM: Simply put, remove the  
9 barriers to virtual care so they are treated  
10 similar to in-person care. Expanding the access  
11 for either in-person, virtual, or a mixture of  
12 the two.

13 It's just really simple. Just make it  
14 simple and make sure we don't build a system so  
15 arcane and complex and byzantine that patients  
16 are getting surprise bills or lack of access, and  
17 providers and facilities are at constant risk of  
18 noncompliance when they're simply trying to do  
19 the right thing.

20 Really simply actually. Just treat it  
21 like any other kind of care.

22 VICE CHAIR TERRELL: Wonderful.

1 Chad.

2 DR. ELLIMOOTTIL: Thanks. So Lee said  
3 it better than I was probably going to, but I'll  
4 -- these are my -- my two points is -- one, is  
5 that simplicity is extremely important.

6 So fragmented coverage and over-  
7 regulation is why less than one percent of  
8 Medicare patients have never used telehealth,  
9 even though telehealth was actually covered and  
10 paid for for the last 20 years.

11 And it's because of these, you know, a  
12 patient has to go to a certain location, has to  
13 be in a certain area, the path of least  
14 resistance has been not to use it. So simplicity  
15 is going to be extremely important for  
16 policymaking.

17 And then the second important point is  
18 that as you think about the sort of paying for  
19 telehealth coverages, the financial gain from  
20 using telehealth must outweigh the costs of using  
21 it and whether -- cost of implementing it,  
22 whether that's in a fee-for-service environment

1 or whether that's in an Alternative Payment  
2 Model.

3 In order to think about that, you have  
4 to think about the entire episode of care. So  
5 it's not just reimbursing for remote monitoring,  
6 but also the interventions that are needed to  
7 help get that desired outcome, whether it's  
8 community paramedics or home infusions, whatever  
9 it may be. Thanks.

10 VICE CHAIR TERRELL: Thank you.

11 And, Sophia, you started this with  
12 your marvelous thoughtful approach as a patient  
13 advocate and thinking about disability, so I'm  
14 going to let you finish with your advice to the  
15 Secretary.

16 MS. TRIPOLI: Sure. Thank you so much  
17 and thank you for the opportunity for Families to  
18 be here today.

19 Just three points. I think the first,  
20 as we've heard from others, is unleash the data.  
21 It needs to flow. It needs to be interoperable.

22 The second is integrate telehealth

1 into existing Alternative Payment Models. We're  
2 already shifting the economic incentives to be  
3 prospective, et cetera. There are already models  
4 that are doing this. CPC+<sup>22</sup>, Track 2, Primary  
5 Care First.

6 And then third, when we're building --  
7 modifying existing APMs or building new ones, get  
8 -- leverage them to reduce the digital divide.

9 Get direct support professionals,  
10 including community health workers, patient care  
11 navigators, social workers, into the care teams  
12 so they can work directly with patients and help  
13 provide illiteracy skills, et cetera.

14 And then, you know, figure out how to  
15 leverage APMs to get technology into patients'  
16 hands.

17 When providers are not relying on fee-  
18 for-service and are in an APM, the shift to  
19 economics allows them to get a tablet, get a  
20 computer into their patient's hands so that they  
21 can actually overcome some of that digital

---

22 Comprehensive Primary Care Plus (CPC+)

1 divide. Thank you very much.

2 VICE CHAIR TERRELL: Okay. You've all  
3 been wonderful, and I want to thank all of our  
4 panelists for their keen insight.

5 We are grateful that you've shared  
6 your time, experience, and ideas with the  
7 community, with our audience here today.

8 As Jeff said this morning to our  
9 previous panel, if -- this would be the point in  
10 the Great Hall that we would ask for applause,  
11 but I'm just going to give you snaps right now.  
12 So this is awesome.

13 So at this point, I'm going to turn  
14 things back over to Jeff as we're going to move  
15 into our public comment period. Thank you all  
16 very much.

17 CHAIR BAILET: Thanks, Grace, and I  
18 echo your appreciation for the panelists. That  
19 was great discussion.

20 I look forward to digesting it, and  
21 hopefully we'll be incorporating that feedback  
22 into our evaluations of upcoming proposals as we

1 move forward. So really appreciate your time  
2 today and expertise. That was awesome.

3 \* **Public Comments**

4 We're going to move into the public  
5 comment period, as Grace said. We have, I think,  
6 five folks who are signed up.

7 The rules of engagement here are each  
8 commenter will be limited to two minutes, if we  
9 could.

10 The folks on the staff will unmute  
11 each individual after I call them and then feel  
12 free to go ahead and start commenting.

13 So first up is Harold Miller, who is  
14 with the Center for Healthcare Quality and  
15 Payment Reform.

16 MR. MILLER: Thanks, Jeff. I  
17 appreciate the opportunity to be here.

18 Can you all hear me?

19 CHAIR BAILET: Yes.

20 MR. MILLER: It's very clear from your  
21 discussion today that in a large number of  
22 circumstances, telehealth is a highly beneficial

1 service for patients, and in a lot of  
2 circumstances, it's an essential service.

3 It's also quite clear that telehealth  
4 can't be delivered if not paid for. And until  
5 six months ago, most telehealth services were not  
6 paid for.

7 Today, Medicare is paying separate  
8 fees for those services in addition to all of the  
9 other thousands of fees it pays for office-based  
10 services. That's a payer-centered approach, not  
11 a patient-centered approach.

12 The patient-centered approach is to  
13 pay providers to diagnose or treat a patient's  
14 health problem in a way that gives them the  
15 flexibility to use whatever approach or location  
16 will have the best outcome at the lowest overall  
17 cost.

18 A number of physicians and provider  
19 organizations have designed payment models that  
20 will do just that, provide flexible, patient-  
21 centered payments tied to outcomes, not to  
22 specific places.

1           PTAC has recommended a dozen of these  
2 models over the past three years. Unfortunately,  
3 CMS has not implemented a single one of these  
4 models.

5           If CMS had implemented them, tens of  
6 thousands of patients could have been benefitting  
7 from telehealth services long before the  
8 pandemic.

9           CMS has said that it would take them  
10 years to implement PTAC's recommendations and  
11 that they don't have the bandwidth to do that.

12           Miraculously, though, CMS found the  
13 bandwidth this spring to issue over 100 pages of  
14 regulations making 50 separate changes to  
15 Medicare payment rules, more than two dozen of  
16 which were related to telehealth.

17           It certainly didn't take physicians  
18 years to implement the changes. Almost  
19 overnight, the use of telehealth services  
20 skyrocketed.

21           It was clear that the payment system  
22 was the biggest barrier, not physician or patient

1 resistance.

2 It shouldn't require a pandemic in  
3 order to get the changes in payment that will  
4 help patients get better care.

5 Congress clearly needs to change the  
6 law so that CMS is required to implement more  
7 physician-focused payment models more quickly.

8 And I urge PTAC to recommend that to  
9 Congress that they change the law in the report  
10 you issue after today's meeting.

11 CHAIR BAILET: Thank you, Harold.

12 We're going to go with Gretchen Alkema  
13 with the SCAN Foundation. Thank you.

14 VICE CHAIR TERRELL: Yes. Gretchen  
15 dropped off. They're trying to reach her. If  
16 you could go to the next one, please.

17 CHAIR BAILET: Okay. We have Keisha  
18 Houston, a researcher. Keisha.

19 MS. HOUSTON: Yeah. I listened to  
20 everyone, and it's a joy to be here. This is not  
21 speculating, but it's kind of an inspiration to  
22 see how these things are addressed about what we

1 need to do and how more proposals need to go out  
2 as far as asking to what needs to be  
3 accommodated. Especially, one gentleman had  
4 brought up about payment issues.

5 Now, a reduction of collaborating a  
6 lot of issues, but reducing payments because of  
7 certain places not paying, you know, becomes an  
8 issue with us especially when it comes to, you  
9 know, we have to, you know, ask and try to find  
10 certain areas that will help, and it's not easy.

11 So we just do what we have to do, you know.

12 And some of these questions is an  
13 inspiration about, you know, about trying to  
14 collaborate and trying to be more, you know,  
15 into, you know, into what things need to be done.

16 So yeah, I'm new at this, but, you  
17 know, the question that has been issued as far as  
18 payments and what can be paid, what cannot be  
19 paid, say, for instance, on dialysis or other  
20 issues that have been, you know, brought up, you  
21 know, it's just trying to find, you know, who  
22 will, you know, or who can we ask for, you know,

1 this mission to happen.

2 But, you know, as far as this concern,  
3 you know, it is going to be taken care of, you  
4 know, and just an inspiration as far as everyone  
5 issuing -- bringing up what needs to be done and,  
6 you know.

7 And so we're going to do more better  
8 than what we do then. Thank you.

9 CHAIR BAILET: Thank you.

10 We have Kelli Garber from the MUSC  
11 Center for Telehealth. You're next.

12 (Pause.)

13 CHAIR BAILET: Kelli, are you with us?

14 MS. GARBER: I'm muted. Hi. Can you  
15 hear me now?

16 CHAIR BAILET: Yes, we can.

17 MS. GARBER: Thank you.

18 I appreciate the opportunity to share  
19 some thoughts with the group and enjoyed the  
20 discussion. It was very informative, and I  
21 appreciate that.

22 I'm speaking today on behalf of nurse

1 practitioners, particularly the National  
2 Association of Pediatric Nurse Practitioners  
3 where we're experts in pediatrics and advocates  
4 for children.

5 As everyone has shared today,  
6 telehealth is an efficient and effective method  
7 of care delivery.

8 I've seen firsthand the difference it  
9 makes in the lives of children and families,  
10 particularly those with special health care needs  
11 and chronic conditions.

12 It's important that barriers to  
13 telehealth utilization continue to be removed,  
14 including those resulting from lack of  
15 reimbursement.

16 It's very important that any  
17 reimbursement modification be inclusive of  
18 advanced practice registered nurses and  
19 particularly nurse practitioners.

20 Nurse practitioners of all specialties  
21 provide quality, comprehensive care. Extending  
22 the reach of their care beyond clinic walls may

1 make a significant difference in improving health  
2 outcomes and health equity.

3 Including APRNs in telehealth practice  
4 can make an Alternative Practice Model more  
5 efficient and patient-centered.

6 As health care continues to shift  
7 towards value-based care, it's crucial that APRNs  
8 be included in payment models that are flexible,  
9 innovative, and improve patient outcomes.  
10 Telehealth can contribute to the success of these  
11 models.

12 Using various modalities of telehealth  
13 to extend the continuum of care may contribute to  
14 achieving the quadruple aim of improved outcomes,  
15 improved clinician experience, improved patient  
16 experience, and lower health care cost.

17 Using telehealth to reach patients  
18 where they are, such as children in school or in  
19 their homes, may improve health outcomes, reduce  
20 the frequency of unnecessary emergency department  
21 visits, reduce costs, and reduce missed work time  
22 for parents and class time for students.

1           It's time that we re-imagine health  
2           care. Embracing telehealth and being inclusive  
3           of nurse practitioners is essential to the future  
4           of health care in our country. Thank you.

5           CHAIR BAILET: Thank you, Kelli. And  
6           that actually concludes the public comment  
7           section of our meeting.

8           \*           **Committee Discussion**

9           I'd now like to turn it over to -- as  
10          we close out this incredible day, we have some  
11          time for the Committee members to discuss and  
12          reflect on what they've heard today.

13          The learnings from our sessions and  
14          discussions here today will be compiled and  
15          shared online and with the Secretary of HHS.

16          Similar to when we wrap up our  
17          deliberations in voting on proposals, I invite my  
18          fellow Committee members to share any additional  
19          insights or specific points that maybe you would  
20          like to emphasize in our report on telehealth.  
21          Thank you.

22          So I open it up to the Committee.

1 (Pause.)

2 CHAIR BAILET: Just anybody can just go  
3 ahead. You guys -- there's just a few of us  
4 here.

5 DR. WILER: I'll jump in, and thanks  
6 for the opportunity to ask questions.

7 I guess much like Grace did, I guess I  
8 should, for the record, disclose a potential  
9 conflict of interest in that I am a co-founder of  
10 our health system's CARE Innovation Center where  
11 we partner with digital health companies to grow  
12 and scale their submissions.

13 And I believe strongly that payer,  
14 provider, and technology partnerships are  
15 critically important to help us solve these  
16 issues.

17 And I think we heard some wonderful  
18 best practices that are working well. And I  
19 think alignment around identifying care models  
20 and the message is not one care model, it may be  
21 multiple care models based on patient  
22 preferences, is an important consideration.

1           And then how the payment model aligns  
2           with those care models, again, it may not be one  
3           solution, but it cannot be 20 solutions, right?  
4           At some point, there needs to be simplification  
5           of the process.

6           We have many tests of change that are  
7           working. I think COVID has given us the awesome  
8           opportunity to see when there is a crisis, we can  
9           move quickly to improve the health of our  
10          patients across the United States and ultimately  
11          our population.

12          So we can do it, and I hope that some  
13          of the tactical components that were described  
14          here, that we can highlight and leverage this as  
15          an opportunity to make some significant change or  
16          influence change.

17          CHAIR BAILET: Thanks, Jen.

18          Josh, do you want to go next?

19          (Pause.)

20          CHAIR BAILET: Josh, can you hear me?

21          DR. LIAO: Oh, yes. Sorry, Jeff.

22          There was a little glitch on the web there.

1           So my comment builds on Jennifer's,  
2           and it's that the two things that really struck  
3           me from this last session was this idea of  
4           flexibility, but the need for simplicity.

5           And I don't think those are  
6           necessarily at odds on their faces, but it does  
7           highlight the potential tension between kind of  
8           having many different tests of change that can be  
9           useful and then moving towards a place where, as  
10          other have said, we can't have 20, 30, 40  
11          solutions.

12          And so the thought I'm left with is  
13          this idea of sequencing and how we think about  
14          when, how, and where do we encourage more  
15          flexibility, perhaps the cost of simplicity,  
16          recognizing that, versus when and how do we move  
17          towards simple solutions that can be scaled, but  
18          recognizing that that may come at some level of  
19          less flexibility. So I'd like that to be  
20          reflected in the report.

21                   CHAIR BAILLET: Great. Thank you, Josh.

22                   And I think we'll have time to sort of

1 look at the draft and make sure that the points  
2 that were raised by the panelists in both panel  
3 sessions get incorporated.

4 There were a lot of tactical comments  
5 that were made from security sort of tracking  
6 challenges, technology challenges, to more global  
7 concerns that were raised regarding payment  
8 parity, a patient-centered approach, as Harold  
9 pointed out, and interoperability and not -- the  
10 one thing that I think, Jay, you raised about the  
11 silo.

12 The last thing we need right now is  
13 creating a silo -- yet another silo. So you  
14 know, an electronic health records sinkhole or  
15 now it will be a telehealth sinkhole, we  
16 definitely don't want that.

17 And so here's an opportunity since  
18 we're starting -- you know, we're just putting up  
19 the tracks now, we're laying the tracks, we have  
20 an opportunity to get it right.

21 And so I'm hopeful that the guidance  
22 that we can provide in this document that we're

1 going to create will help us get to that end.

2 Any other comments? I didn't see  
3 anybody else raise their hand.

4 Grace?

5 VICE CHAIR TERRELL: Yeah, just one  
6 thing that's not specific about the actual topic  
7 today, but just an insight that I had with just  
8 the richness of this discussion as it relates to  
9 a topic by having not only the -- it's the very  
10 thoughtful comments from the previous submitters  
11 this morning to the expertise this afternoon  
12 created something I hope we can think very deeply  
13 about as a Committee as we're going forward with  
14 our ongoing, you know, processes and thinking  
15 through.

16 So -- and then we'll likely talk about  
17 that a little bit more in our administrative  
18 session among ourselves, but I just wanted to say  
19 in the public meeting that I, for one, found this  
20 to be rich and useful and beneficial and would  
21 certainly want to find out from the public and  
22 other, you know, other stakeholders whether

1       whatever work product comes out of this after we  
2       talk in more detail in the public meeting in  
3       December about this, as to whether this is a --  
4       something that we need to do on an ongoing basis.

5               I believe it is, and we, as PTAC, of  
6       course will think about what might be our next  
7       thematic meetings, but this is our first.

8               And so I think it's going to be really  
9       important for us to understand from everybody, is  
10      this going to be useful going forward? I, for  
11      one, thought it was wonderful.

12              CHAIR BAILET: Thanks, Grace.

13              And I know, Luran, you had a comment  
14      you wanted to make or a question.

15              MS. HARDIN: You know, this is  
16      incredibly rich, Jeff. There's a few themes that  
17      are really interesting to me.

18              So first of all, how aligned everyone  
19      was in their comments across sectors was very  
20      interesting to me.

21              And then how valuable telehealth has  
22      been with behavioral health is a theme that's

1 coming up around the country, which I didn't  
2 expect.

3 And then the emphasis on  
4 interprofessional, interdisciplinary, and  
5 interorganizational collaboration and design of  
6 that and what we look at with telehealth.

7 And then finally, the transformational  
8 value of including the perspective of startup  
9 costs and education or co-learning when we look  
10 at financing telehealth.

11 \* **Closing Remarks**

12 CHAIR BAILET: Thanks, Luran, and  
13 thanks everyone. I mean, this was a little bit  
14 of -- we were astronauts today.

15 This is the first time that PTAC has  
16 embarked on a session -- holding a session like  
17 this.

18 But, as Grace said, it's been  
19 incredibly rich, incredibly valuable. It will  
20 help sharpen our thinking and our approach to  
21 evaluating models and making recommendations on  
22 the go forward.

1           I want to thank everybody for  
2 participating today and members of the public,  
3 panelists, public commenters, and obviously my  
4 colleagues on the Committee.

5           We've covered a lot of ground today on  
6 a very important topic, and you can keep an eye  
7 out for our resulting compilation in the coming  
8 weeks.

9           We're also issuing another round of  
10 questions for public input, as Grace pointed out,  
11 and this time focused on telehealth.

12           And we will be posting those online  
13 and sending them out to the PTAC distribution  
14 listserv, which you can join on the ASPE PTAC  
15 website.

16           Thank you all for taking time out of  
17 your busy schedules to join us, please take care  
18 and be well, and this meeting is adjourned.  
19 Thank you.

20           (Whereupon, at 1:27 o'clock p.m. the  
21 meeting was adjourned.)

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Advisory Committee Virtual Meeting

Before: PTAC

Date: 09-16-20

Place: teleconference

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

*Neal R Gross*

-----  
Court Reporter

**NEAL R. GROSS**

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