PEPC
PARTNERSHIP TO EMPOWER PHYSICIAN-LED CARE

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

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

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

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

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

**Questions from PTAC**

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

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

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

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

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

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

the patient's existing care team can be disruptive, particularly when the physician is accountable for patient outcomes under an APM.

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

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

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

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

We believe research opportunities exist in the following areas:

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

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

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

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

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

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

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

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

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

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

Best,

Kristen McGovern
Executive Director