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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TUESDAY, DECEMBER 8, 2020

PTAC MEMBERS PRESENT

JEFFREY BAILET, MD, Chair
PAUL N. CASALE, MD, MPH, Vice Chair
CARRIE H. COLLA, PhD
JAY S. FELDSTEIN, DO
LAURAN HARDIN, MSN, FAAN
JOSHUA M. LIAO, MD, MSc
TERRY (LEE) MILLS JR., MD, MMM
BRUCE STEINWALD, MBA
JENNIFER L. WILER, MD, MBA

PTAC MEMBERS IN PARTIAL ATTENDANCE

KAVITA K. PATEL, MD, MSHS

PTAC MEMBERS NOT IN ATTENDANCE

ANGELO SINOPOLI, MD

STAFF PRESENT

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

A-G-E-N-D-A

1 Physician-Focused Payment Models

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

10:01 a.m.

* CHAIR BAILET: Welcome to the public meeting of the Physician-Focused Payment Model Technical Advisory Model Committee known as PTAC. I'm Jeff Bailet, the Chair of PTAC. Because of the coronavirus pandemic, we're holding this meeting virtually rather than gathering in the Great Hall of the Humphrey Building[2].

Our goal is for a seamless virtual experience as close to in-person PTAC meeting as possible. That said, we appreciate your understanding in advance if any technical challenges arise, such as sound delays or background noise.

If you have any technical questions, please email our contractor team at PTACRegistration@norc.org. Again, that's PTACRegistration@norc.org. If you've joined via Webex, you can also message the meeting host with any questions.

2 Hubert H. Humphrey Building

Many PTAC stakeholders are directly involved in responding to the pandemic, and we are thankful for your service to our country.

We want to thank providers, support staff, caregivers, family members, and others who are supporting patients during the pandemic. We recognize that it's a privilege to have you joining us today.

PTAC is committed as ever to having a submitter-driven process. So, I remind you that the Committee accepts proposals on a rolling basis. Many potential future submitters may be focused on the pandemic.

So, I remind anyone that you do not need to worry about finishing your proposal to meet a specific deadline.

The pandemic has highlighted many challenges in our health care system, in addition to prompting an unprecedented expansion of telehealth.

At our September public meeting, we debuted an additional mechanism for PTAC to

garner information that can inform our review of proposals and raise awareness on key topics related to value-based transformation.

The meeting included a discussion of telehealth and Alternative Payment Models, complete with panel discussions; information on previous PTAC proposals that included telehealth as a component; and a public comment period.

Following the September meeting, three Committee members formed the Preliminary Comments Development Team and commenced its review of the discussion, key points raised at that time, as well from the input that came in via our telehealth Request for Input, or RFI.

Following careful consideration of all of the meeting input and submitted information, they developed a set of suggested comments on recommendations, policy considerations, and research questions that they will present to the full Committee today.

In turn, the full Committee will review what we learned in September and from the

RFI and discuss the comments and recommendations we want to convey to the Secretary in a synthesized report on telehealth. The theme-based meeting discussions represent one of several ways that PTAC continues to evolve to meet a changing landscape.

We, as a Committee, routinely evaluate our processes so that we remain well-positioned to advise the Secretary on new ideas related to payment models from the field, as is our charge, and so that we can best activate and engage with stakeholders to solicit such ideas and information.

We're also called to serve those stakeholders who seek to provide innovative ideas that aim to address care delivery, quality, and payment transformation.

To that end, we are exploring opportunities through process changes or other approaches that could expand and enhance our ability to receive a broader array of proposals and further engage with stakeholders.

We have a unique opportunity with today's public meeting. We will discuss the input we have received from a variety of stakeholders over the year, in addition to continuing our exploration of telehealth and Alternative Payment Models.

As you may recall, in September we convened two different panels of experts to discuss telehealth and payment models: one panel of submitters whose proposals to PTAC had included telehealth and another of additional experts representing several perspectives.

We also issued a Request for Input to gather even more public input on the topic, and we're pleased to receive many responses.

Three PTAC members who comprise the Preliminary Comments Development Team have been hard at work leveraging the holistic insights we learned about and synthesizing them into potential content for a report to the Secretary on telehealth and payment models.

As I mentioned, they will present

their recommendations, and we will discuss how their work will be incorporated in a report to the Secretary. Then we'll wrap up the day with a public comments period.

Before we begin our first presentation, I have some announcements to make about PTAC's work and its membership since our last meeting in September.

At the public meeting, we deliberated on two proposals: one submitted by the American College of Physicians and the National Committee for Quality Assurance and another submitted by ASCO, the American Society of Clinical Oncology.

We have since published our reports to the Secretary on these proposals, which you can find online. Additionally, I'm excited to welcome two new members of PTAC.

Dr. Carrie Colla is a Professor at the Dartmouth Institute for Health Policy and Clinical Practice, which is part of the Geisel School of Medicine at Dartmouth College. Also, Dr. Terry (Lee) Mills is the Senior Vice

President and Chief Medical Officer of CommunityCare. Welcome.

They were appointed by the Government Accountability Office in October and have been diligently preparing to participate today.

I'm also pleased to announce that PTAC has a new Vice Chair, Dr. Paul Casale. Paul is one of the founding members of PTAC, and I look forward to our partnership. Thank you, Paul, for agreeing to take on these additional responsibilities and service to the Committee.

I'd like to say a word about one of our members who has reached her term limits on the Committee since our last public meeting. Dr. Grace Terrell, one of PTAC's founding members, and contributed to the Committee's work in many ways, including by serving as PTAC's Vice Chair for the last two years.

We're grateful for her service to the Committee, especially her vision in designing these telehealth discussions, and we will miss her greatly. I think I speak for all of my

fellow Committee members when I say that I look forward to our paths crossing again.

*** PTAC Member Introductions**

And now, I would like PTAC members to please introduce themselves. Please share your name and your organization.

If you would like, feel free to share a brief word about the experience you've had with telehealth, our main topic for today. And because of our meeting, because it's virtual, I'll cue each of you and I'll start with myself. I'm Jeff Bailet, the CEO of Altais, a physicians' services organization. Paul.

VICE CHAIR CASALE: Hi, Jeff. Paul Casale, a cardiologist. I lead Population Health at New York-Presbyterian, Weill Cornell and Columbia.

CHAIR BAILET: Carrie.

DR. COLLA: Carrie Colla. Jeff already gave me a little bit of an introduction. I'm an economist at the Dartmouth Institute for Health Policy and Clinical Practice and have a

lot of experience with research and payment models and participate in a lot of qualitative and quantitative research about physicians' practices.

My experience with telehealth has mostly been on the patient side so I'll keep comments mostly about what I've read in the literature. Thanks.

CHAIR BAILET: Thanks, Carrie. Jay.

DR. FELDSTEIN: I'm Jay Feldstein. I'm the President and CEO of Philadelphia College of Osteopathic Medicine.

My experience with telehealth is that in our set of primary care clinics when the pandemic started, we had to pivot from in-person to virtual in the span of a week, and it's been a very interesting experience for both providers and patients.

CHAIR BAILET: Thanks, Jay. Lauran.

MS. HARDIN: Good morning, I'm Lauran Hardin, and I'm a Senior Advisor for the Camden Coalition’s National Center for Complex Health

and Social Needs. My experience with telehealth over the last year has been working with sites around the country who are building models for complex populations, as well as to respond to the social disaster from the pandemic, and telehealth has been integral in all of those across the board, across the community.

CHAIR BAILET: Thank you, Lauran. Josh.

DR. LIAO: Morning everyone, Josh Liao here. I'm an internal medicine physician and the Medical Director for Payment Strategy here at UW[3] in Seattle.

My experience with telehealth has been a dynamic one at our organization where so much has changed. The volume of telehealth really swelled in the earliest phases of the pandemic, contracted, and as we swelled, and so, definitely something that I'm still continuing to think about and work on.

CHAIR BAILET: Thanks, Josh. Lee.

3 University of Washington

DR. MILLS: Good morning. Lee Mills. I'm a family physician and Senior Vice President, Chief Medical Officer at CommunityCare, a regional-based provider and health plan in Oklahoma.

My experience with telehealth has been pretty deep both as a clinician using it in patient care and in medical group operations and administration, organizing networks and physicians, and then on the health plan side where we continue to support four or five thousand telehealth visits per week among our beneficiaries.

CHAIR BAILET: Thanks. Bruce.

MR. STEINWALD: Bruce Steinwald. I'm a health economist here in Washington, D.C., and I'm looking forward to m y first telehealth visit later this year.

CHAIR BAILET: Okay, Bruce. Jen.

DR. WILER: Good morning, I'm Jennifer Wiler. I'm the Chief Quality Officer at UCHealth

Denver4. I'm also a Professor of Emergency Medicine for the University of Colorado. I'm a co-founder of UCHealth CARE Innovation Center where we partner with digital health companies where we can provide remote monitoring services.

And with regards to telehealth, I also served for 11 years within the American Medical Association RBRVS[5] Updates Committee, where we evaluated CPT[6] codes related to telehealth services.

And finally, as a provider, our health system provides virtual care services for patients within the Rocky Mountain Region, and I do that myself as a provider.

CHAIR BAILET: Thanks, Jennifer. And I don't know, Kavita? Kavita may not be, she may not be yet joining us.

MS. AMERSON: Not yet.

CHAIR BAILET: Not hearing her, we're going to go ahead. So, thank all of you. At

4 University of Colorado Health
5 Resource-Based Relative Value Scale
6 Current Procedural Terminology

this time, let's move to our initial presentation. After our public meeting in June of this year, we issued a Request for Input to learn from stakeholders on how we might expand our review of proposals.

All of the responses received are on the ASPE PTAC website, and ASPE staff will present some of the key point shortly. To my colleagues on the Committee, after the presentation, we will discuss our reactions and some thoughts on how we could incorporate this information to improve our existing processes.

* **Informing PTAC's Review of PFPMs - Presentation on Public Input Received**

I'm going to now turn it over to Stace Mandl to present on what we learned from the public responses to the RFI. Stace.

MS. MANDL: Thanks, Jeff. Good morning everyone, and thank you everyone for joining today. It's an honor to be here this morning and report out on PTAC's June Request for Input.

I'm Stace Mandl, and I serve as the PTAC Staff Director here at ASPE. Next slide please. This RFI was released in June, shortly after the public meeting when PTAC announced its vision.

The RFI aligns with PTAC's vision statement and in particular its vision to activate stakeholders and increase awareness of issues related to payment and care delivery as identified by frontline stakeholders. Next slide.

This RFI included four questions that were posted on ASPE's PTAC webpage. The first question was what are the current challenges in health care delivery and payment?

What is needed to push forward on addressing care delivery issues and Alternative Payment Models? Are there actual and potential PFPMs7 that have not been addressed in proposals submitted to PTAC so far?

What other factors would be important

7 Physician-focused payment models

to take into consideration to inform PTAC's evaluation of proposals, including factors related to engagement and adoption of models?

How might a proposed PFPM build on the learnings from earlier models? And lastly, how might care models that are included in the proposals reviewed by PTAC be incorporated in broader models like ACOs[8] or Direct Contracting? What factors would be important to take into consideration such as barriers or facilitators for adoption? Next slide.

PTAC received several responses to the RFI, one of which represented several specialty societies organized by the American College of Physicians. Next slide, please.

Respondents submitted comments on several topics regarding challenges in priority areas, including coordination and integration of care across services.

For example, comments included: ''Fragmentation in health care increases, medical

8 Accountable Care Organizations

errors and poor outcomes, system waste and inefficiencies, and dissatisfaction for all parties. These effects are compounded when patients have multiple clinicians involved in their care.''

Another comment was: ''PTAC should give priority consideration to models that support and reward high-value interactions across settings.'' And another commenter stated: ''One of the central considerations when it comes to existing models is the lack of engagement between specialty and primary care clinicians.''

Other topics raised in comments signaling priority areas for PTAC included ''Social determinants of health, proposals with specific clinical focus areas, including primary care or care for individuals with serious illness, the needs of small or rural providers in the context of APMs[9], valuation and costs, benchmarking and quality measurement, and provider and patient attribution.'' Next slide,

9 Alternative Payment Models

please.

Respondents also flagged for PTAC to take into consideration in their reviews proposals that are for specialists; are about serious illness; address the cost of homecare; integrate non-physician providers; engage community-based organizations; engage caregivers; impact underserved and minority communities; increase financial stability for providers; offer up-front investments for small, rural, and primary care providers; and balance quality with savings to avoid stinting.

For example, one commenter expressed: ''There is an opportunity for new models to be implemented or for existing models to expand in such a way that bridges the chasm between primary and specialty care and engages specialists in more robust ways, including by promoting specialist participation in the financial rewards and the risks of the model.'' Next slide, please.

Stakeholders also flagged the importance of stakeholder engagement in

activation. One commenter stated: ''Signal that PTAC is a viable path for clinicians to meaningfully participate in value-based care models that directly apply to the care in which they provide.''

Another commenter expressed: ''Providing scalable opportunities for specialists not previously engaged in value-based care models should be a priority for PTAC in HHS[10] moving forward.''

These and other comments taken together underscore the theme-based discussions at the public meetings can help to raise awareness of issues and priorities identified by stakeholders.

And that such input, such as that provided via this RFI and proposals themselves can serve to highlight important issues and specific needs in priority areas in value-based care transformation. Next slide, please.

The comments are available on the ASPE

10 U.S. Department of Health and Human Services

PTAC website. The RFI and input received in total is posted on our website.

And I want to thank you again for the opportunity to report out on PTAC's June RFI and, Jeff, thank you and the Committee for your service, and at this point, I'll hand things back over to you.

CHAIR BAILET: Thanks, Stace. We appreciate you walking us through all of that information, and we want to thank those who put time and effort into sharing their perspectives with us. I want our stakeholders to be assured that we want to be responsive to what we've heard.

So, we've already begun to work on digesting the ideas you've raised and thinking creatively about how we can incorporate them into our processes.

For my colleagues on the Committee, this is just one of multiple opportunities we'll have today to discuss what our community of stakeholders is telling us and how we can adjust

our processes accordingly.

I welcome thoughts from my fellow PTAC members about the broad strokes of directions we'd like to move in or we can save some of the operational details for later.

But I'd like to get your thoughts on any ideas that you have. So, I'm just going to open it up to Committee members and, you know, we'll have a discussion.

VICE CHAIR CASALE: Jeff, I'm happy to start while others are thinking. This is Paul. You know, I think there's several themes that came through those comments but one, certainly one of the consistent ones I just wanted to highlight was around this primary, engagement of primary care and specialists, and how to engage specialists in the models. It seems to be an ongoing challenge around the current models, and even we have seen that as we've commented on several other models that have been brought previously before PTAC.

So, just wanted to flag that in

particular as something that was certainly consistent through the comments that we heard from, through this RFI.

CHAIR BAILET: I also think, Paul, to that point, there's challenges where physicians are in models, particular specialists already, and if there's a new proposal, you know, how do they figure out which camp they're in or which models they're participating in? That's also been a challenge for the specialists as well. Carrie.

DR. COLLA: Another thing that struck me reading through them was, in addition to what Paul said about involvement of specialist is about the fragmentation across both settings and different types of clinicians.

I think nearly all of them really focused on that and how you can create models that work on fragmentations, not within a silo but across settings and providers.

CHAIR BAILET: Thanks, Carrie. Anyone else?

VICE CHAIR CASALE: Along these lines, this is Paul again, I just wanted to again, when we think about that care coordination, the engagement and as Carrie said around fragmentation, you know, not only, there's often again, just to flag sort of on the clinical model has sort of been worked out, but the financial model. So, how do the different specialties and primary care, there's often confusion around the sort of, how the finances work and, Jeff, I guess to your point about, you know, if the specialist is in one model and then maybe in another one and trying to understand how that all works, sometimes there's quite a bit of confusion around how the finances work around those things.

DR. LIAO: Hi, this is Josh. I would just, you know, bringing together Carrie and Paul's points about not just specialty and primary care, not just phases of care but kind of the interaction between the two, right.

That the coordination will look perhaps different for primary and some specialty

care and outpatient setting and the acute setting and the post-acute setting.

And thinking about those as distinct and then kind of creating payment structures around each of those or kind of working them together, I think is, it's a critical piece.

MS. HARDIN: This is Lauran, and to build on what Josh said, also the, interprofessional cross-sector nature of the coordination that's occurring now and how that's shifting the way people are looking at payment.

So, in order to really have a high-quality patient experience through the lens of the person, it's involving integrating social services, community-based organizations, and other funding streams.

And I think that will be our challenge going forward -- is what are those payment models look like when we actually look at it through a community lens and an equity lens?

DR. COLLA: Jeff.

CHAIR BAILET: Thanks, Lauran. Other

comments?

DR. COLLA: One other comment on a little bit of a different topic is that a few of the respondents also mentioned risk adjustment and kind of the inability of risk adjustment to keep up with these models, and thinking about new ways to approach risk adjustment to make these models work better.

CHAIR BAILET: Yes, I think that's a good point, Carrie, and also there's, I don't want to say disparities but there are significant differences between the clinic settings.

We've also been working with the stakeholders who are in rural or small practices versus urban or academic centers. There are some nuances there that have played through as it relates to the robustness of the models.

DR. COLLA: Particularly around social needs, I think we're just starting to get into concrete methods of how to adjust for social needs in particular and some of them mentioned that.

CHAIR BAILET: Right. Additionally, I think it would be great to let the public know that we are wanting to make sure that the pipeline for proposal submissions continue.

And we understand that part of what we're seeing as it relates to a little hiatus in proposal submissions now, could be related and probably somewhat related to COVID and everyone hunkered down to address the pandemic.

We also want to make sure that we don't stifle the innovation, which was the premise for standing up the PTAC.

And so, we're working internally to figure out, is there ways that we can sort of engage with stakeholders to foster the ability for them, for the stakeholder community to submit models that may not have all of the attributes that would be required under the Secretary's criteria, but are strong enough in their innovative ideas that we would still want to consider them, and there'll be more to follow on that as we internally are figuring out how that

could potentially shape up.

I just wanted to alert the public that we are actively talking about that now because we do want to make sure that folks out there have the opportunity to submit their ideas and innovations going forward.

Any other comments we want to make at this point? All right. So, that was helpful. We'll certainly discuss in more detail. We have administrative meetings, the aspects that we are seeing today in a later session this afternoon.

I'd like to wrap up and transition to telehealth, that portion of our agenda, and we'll begin by reviewing what we learned from our various sources, including panelists and public commenters at our September public meeting, an environmental scan that was accomplished and also a different RFI we released about telehealth. Then we'll have a Committee discussion period to sift through all of what we've learned to identify the policy considerations and research questions that we might include as comments to

the Secretary.

*** Informing PTAC'S Review of Telehealth and PFPMs - Presentation on Public Input Received**

So, let's start by learning what stakeholders shared in response to our Request for Input on telehealth and payment models.

Committee members, just as we did with the previous presentation, I'd like us to discuss any initial reactions you have, so please be ready to share after Audrey gets done with her presentation.

Audrey McDowell is a Program Analyst and member of the ASPE staff team that supports PTAC, and she'll present a synthesis of these responses so, Audrey, please go ahead.

MS. MCDOWELL: Thanks, Jeff. As Jeff stated, my name is Audrey McDowell, and I appreciate the opportunity to review the responses that were received to PTAC's Request for Input on telehealth and physician-focused payment models or PFPMs. Next slide.

Stakeholders submitted 18 PFPM proposals to PTAC that included telehealth as a component, and PTAC held a theme-based discussion on telehealth in the context of APMs and PFPMs during its September public meeting.

And then after the public meeting, the Committee released an RFI on telehealth to gain additional insights from stakeholders. Next slide.

As discussed earlier, PTAC's release of these RFIs is consistent with the Committee's vision of providing a forum for encouraging stakeholders to increase both awareness of important payment and care delivery issues and also, to develop important solutions to these issues. Next slide.

This is an overview of some of the topics that were addressed in the telehealth RFI, ranging from best practices to performance metrics, and beneficiary education needs. A full list of the telehealth RFI questions can be found in the appendix of this slide deck. Next slide.

This is a list of the nine respondents to the telehealth RFI, which included five associations, two other organizations, and two individual physicians. And it's noteworthy that four of the respondents were actually previous PTAC proposal submitters. Next slide.

There was consistency between many of the themes in the stakeholders' responses to the telehealth RFI and the themes from the September public meeting.

The respondents to the telehealth RFI also provided additional insights regarding several topics, including performance-related metrics, monitoring and evaluation methods, and beneficiary education needs.

Additionally, the telehealth RFI responses also addressed some topics that were not specifically included in the RFI. Next slide.

The following are some excerpts from some of the stakeholder responses relating to the need for measures to precisely define which

aspect of telehealth is being measured when considering the impact on cost, quality, and experience of care.

The need for telehealth as another site or modality to be held as another site or modality, rather than type of care, to be held to the same quality and safety standards as other care settings, and potentially to adapt rather than reinvent quality measures for telehealth.

And also, the need for robust education to help beneficiaries understand how to use telehealth. Next slide. Next slide.

Regarding next steps, the information from the responses to the telehealth RFI will be incorporated into today's discussion on telehealth and value-based care transformation, as well as the report to the Secretary, and also, in subsequent PTAC environmental scans related to future PFPM proposals that incorporate telehealth. Next slide. As discussed earlier, the Appendix includes the full text of the questions from the telehealth RFI. Next slide.

All of the responses to the telehealth RFI are available on the ASPE PTAC website and that concludes this presentation. I will turn it back over to Jeff.

CHAIR BAILET: Thank you, Audrey. That was helpful, and it was a great way to begin the telehealth portion of today's meeting. And of course, our thanks to those who shared those insights with us.

Committee members, were there any specific points from the RFI responses that you'd like to discuss at this time before we move into the actual Committee's work on the telehealth initiative?

*** Telehealth and Value-Based Care Transformation - PCDT Presentation and Committee Discussion**

All right. Hearing none, I think we'll just move right in then. As I mentioned earlier, PTAC plans to release a report to the Secretary synthesizing its comments and recommendations from our deep dive into

telehealth and payment models.

As I noted earlier, the Preliminary Comments Development Team, which is a new team for PTAC, had focused on synthesizing what we've learned at our September meeting and since then, through the RFI.

They have created a set of slides with potential comments that we could include in our upcoming report, and we'll walk through it with them today. As a quick disclaimer, their findings do not necessarily represent the full Committee's position, and they're not binding.

After their presentation, we'll discuss their findings and the extent to which we would like their recommendations to be part of our final report.

At this time, I'd like to turn it over to Jay Feldstein, the Lead of the Preliminary Comments Development Team, who'll report out to the full Committee the team's suggested comments.

At four separate points during his presentation, Jay will review the suggested

comments for Committee deliberation. To stay on track with the day's agenda, we should plan on keeping our deliberations for each segment to about 10 minutes.

I think we have maybe a little bit more time, since we're a little ahead right now, but needless to say we'll try and stay on track and, Jay, please go ahead. You're on mute, sir.

DR. FELDSTEIN: That's better. Thank you, Jeff. Good morning, everyone. This is our report on our Preliminary Comments Development Team findings on the role telehealth can play in optimizing health care delivery in value-based transformation in the context of Alternative Payment Models and physician-focused payment models.

I'd like to thank my other team members, Carrie Colla and Lauran Hardin, for their hard work and dedication.

And also, to Audrey and Stace, to the ASPE team, for really synthesizing a tremendous amount of information that was relayed to us

during our September meeting. And I look forward to sharing our information with you and to a robust discussion. Next slide.

Today's overview, we'll talk about the background, the Preliminary Comments [Development] Team composition, review process, an overview of key findings relating to telehealth in the context of APMs and PFPMs, and the key issues and potential comments identified by the PCDT[11]. Next slide.

On September 16th, PTAC held a theme-based discussion on Telehealth in the Context of Alternative Payment Models and Physician-Focused Payment Models.

The goal was to provide PTAC with current perspectives on the role telehealth can play in optimizing health care delivery and value-based transformation in the context of APMs and PFPMs in order to further inform the Committee's review of future proposals.

The telehealth session included a

11 Preliminary Comments Development Team

presentation on the 18 previous PTAC proposals with a telehealth component, panel discussions with six past submitters whose proposals included a telehealth component and a diverse group of subject matter experts, and public comments from stakeholders.

Prior to the public meeting, an environmental scan was prepared that provided background information on telehealth, the role of telehealth in the context of APMs and PFPMs, and issues and opportunities associated with optimizing telehealth in an APM.

After the public meeting, PTAC released a Request for Input, an RFI on telehealth and developed a supplement to the environmental scan on telehealth. Next slide.

To prepare for today's discussion, three PTAC members, our team, volunteered to serve on the Preliminary Comments Development Team and one of us serving as the lead. After reviewing the available information, we prepared a summary table and a presentation summarizing

its findings for the full PTAC.

Our findings are typically posted on the PTAC website at least one week prior to public deliberation by the full Committee. Our findings are not binding on PTAC, and PTAC may reach different conclusions from those contained in our presentation.

The report to the Secretary will be prepared based on the results of the full Committee's deliberation, and this is our flow diagram of our process and where we are today. Next slide.

In terms of an overview of our key findings relating to telehealth in the context of APMs and PFPMs, the following of the overview is: there are many different definitions of telehealth, whether it be virtual visits, audio visits, telemonitoring; there are various types of barriers that have affected telehealth use; telehealth use increased during the public health emergency; increased use of telehealth provides opportunities to improve health care; some best

practices for optimizing the use of telehealth services; how to address barriers affecting beneficiaries' access to telehealth; the role of APMs in optimizing the use of telehealth services; and payment issues relating to telehealth services. Next slide.

The importance of considering the relevance of potential comments to APMs and PFPMs. Many telehealth issues and potential comments are broadly applicable to both value-based context and traditional reimbursement arrangements.

During the Committee's deliberations, it will be important to highlight which topics and comments are most important in the PFPM or value-based context. Next slide.

We put our comments into distinct categories. Category One focused on infrastructure for both provider and beneficiary needs. Category Two are barriers and enablers, policies related to access and optimization, and Category Three, payment issues, paying for

telehealth under physician-focused payment models or Alternative Payment Models, and Category Four, what research questions to address the gaps in our knowledge. Next slide.

Category One, provider and beneficiary needs. How do we avoid disparities? How do we focus on vulnerable populations? What are the provider needs? How do we address standards for adoption and use?

And how do we address benchmarks and variation in standards by setting? And how do we understand provider and beneficiary costs? Next slide.

What are our beneficiary needs, and how do we avoid disparities? Our key observations: virtual care can exacerbate disparities in care for vulnerable populations, whether it be underrepresented minorities or those living at home with long-term support service needs.

How do we address those without access to devices, broadband, or comfort using

technology and who face a digital divide? And then populations with physical and cognitive impairments to using technologies have special needs as well.

From a proposed comment perspective, we need to consider sponsoring a report to investigate or describe unintended consequences associated with widespread adoption and the use of telehealth that addresses the potential for exacerbation of disparities in care for specific populations due to the digital divide, cognitive and physical impairments, and long-term support services for those living in the community with limited caregiver support. Next slide.

How do we focus really on vulnerable populations? Aging or disabled populations with long-term service needs and others residing in the community with limited caregiver support are socially isolated with unmet needs.

Visual and hearing impairments and limited caregiver support present challenges to usability. Cultural sensitivity, language

translation services, and attention to health literacy are also needed. And addressing the needs of these populations requires strategic care planning to ensure access to adequate virtual care.

We need to partner with a diverse array of stakeholders, including providers and those representing the beneficiary voice in the development of standards for adopting telehealth to address long-term service needs of community dwelling populations; and to address the impact of social isolation.

Consider further research on unintended consequences of widespread use of telehealth address disparities in care for specific populations, including those with impairments or those who require language translation and culturally competent education. Next slide.

How to address provider needs for standards and adoption in use. Telehealth can provide as needed access to interdisciplinary

providers-- social workers -- for patients, staff in skilled nursing care facilities.

An APM could support a cultural shift from using telehealth as an event, to providing routine access. The rapid adoption of telehealth has led to some providers to adopt new workflows and approaches for determining the need for in-person care.

The key strategies include enhancement of team-based approaches and use of a telephone or audio-only backup in case of technology failure. Telehealth may exacerbate data silos if we're not careful in integrating it with electronic medical records.

From a proposed comment perspective, in the context of APMs, considering developing partnerships with a diverse array of stakeholders -- including providers and those representing beneficiary voices -- to support the development of standards for telehealth adoption, including workflow, service integration, team-based approaches, shifting to a culture of routine

access, and determining when telephone or audio-only access is appropriate and sometimes the only technology available, and the interoperability of data gathered in the context of telehealth, so we do not create an additional silo in health care. Next slide.

And how do we address provider needs from a benchmark and variation in standards by setting? Virtual services cannot fully substitute for hands-on care. Payment parity may be appropriate for insuring access to some services but may introduce program integrity concerns.

Current guardrails to support appropriate protections may not be sufficient. Additional guidelines, quality metrics, and benchmarks may be needed, and different settings, provider types, and clinical scenarios may warrant different standards.

We need to consider partnering with a diverse array of stakeholders to support the development of standards for appropriate adoption

of telehealth by setting.

Modified clinical quality measures for virtual versus in-person care, benchmarks using patient satisfaction measures to convey a virtual care to in-person care, and the use of analytic technology to enforce program integrity rules. Next slide.

How do we understand provider and beneficiary cost? There's a lack of rigorous methods for accounting for provider costs means true cost of adoption is not known. Variation in cost by geographic area and provider type are also unknown.

And beneficiaries may also face costs associated with devices and connectivity. Appropriate APM payment mechanisms to cover these costs require more exploration.

And in the context of APMs, we need to consider exploring interest in partnerships again with a diverse array of stakeholders to support the development of accurate methods to comprehensively account for costs of telehealth

adoption and use for different provider types.

And we need research on costs associated with beneficiary access to broadband connectivity, technologies, tablets, and technical support needed to benefit from telehealth. Next slide.

So at this time, we'd like for PTAC to have a discussion of our suggested comments. In the following two slides, we have summaries of what we've just gone through. I'd open it up to members of my team and also, Mr. Chairman, to give it back to you for a full Committee PTAC discussion.

So, if we could advance to the next slide, which is a summary of what we've gone through, that'll be a good place for us to start. Thank you.

CHAIR BAILET: Thanks, Jay, and I'd look to Carrie and Lauran if you guys wanted to make any additional comments before the full Committee weighs in.

MS. HARDIN: I think Jay covers this

well, Jeff, and I think one of the most important issues we saw in the comments and around the country is the importance of really integrating diversity and equity in the way we look at telehealth.

CHAIR BAILET: Okay. Thanks, Lauran. Nice job, Jay. We're going to open it up to the full Committee. Bruce. You're on mute.

MR. STEINWALD: Thank you, Jeff. Thank you, Jay. Can you hear me now?

CHAIR BAILET: Yes, we can.

MR. STEINWALD: Okay, good. I'm referring back to your slide where you identified program integrity as an issue, and I wanted to comment on that a little bit.

In full disclosure, I spent 10 years at the Government Accountability Office covering health care spending and Medicare spending issues in particular and have a heightened sensitivity of how certain developments may have spending implications that are concerning.

The advancement of telehealth,

especially in the context of the pandemic, is terrific, but with rapid growth there comes the potential for overuse and misuse, and I think we need to be, looking ahead past the pandemic when we have now an infrastructure installed for much more telehealth in the health care system in general.

And how we can make sure that that infrastructure doesn't generate additional, unnecessary spending, and one comment I would make in that regard, and I know you're going to get to this later, is building telehealth into APMs and PFPMs in maybe one very competent way of ensuring that these services are used appropriately and don't create a real problem for Medicare spending.

CHAIR BAILET: Thanks, Bruce. Any other Committee members have comments to make at this point? Carrie.

DR. COLLA: Just to really piggyback on what Bruce said, and I think it's this tension we're dealing with of wanting to create access

while wanting to think about program integrity.

And also, as someone who worries a lot about health care spending and its implications on both public and private budgets, I think we also want to deeply consider situations in which telehealth is substituting for existing care as we saw at the height of the pandemic.

Whereas, research from before the pandemic showed that a lot of telehealth services were supplementing normal care, in which case that would have a bigger implication for overall Medicare spending.

And I think just in considerations to make in that choice, although it is difficult to determine that based on claims, and so in a fee-for-service environment, it's more difficult to try to parse out which of those scenarios you're in.

And so, that's why an APM might be more well suited to this, such as CMMI[12] is using in existing APMs even before the pandemic. And

12 Center for Medicare & Medicaid Innovation

then also that research shows that the effectiveness of telehealth in different clinical scenarios varies.

And so, allowing providers to really be able to make those determinations is also appropriate in the context of APMs over which clinical scenarios are more effective for use of telehealth.

And finally, thinking about the research in terms of telehealth in the context of existing clinical relationships, ongoing continuous care versus outsourced telehealth to other types of providers, and how those might differ in terms of the outcomes they might produce.

CHAIR BAILET: Thank you, Carrie. Other Committee comments?

DR. LIAO: This is Josh, by phone here. I think the comments by Carrie I think are relevant and building on that and what Bruce said about, you know, APMs and PFPMs being maybe a nice way of focusing on integrity.

I think the other perhaps complementary point as I listened to all the really critical and salient issues that Jay outlined, some seemed that they will be particularly relevant to APMs and PFPMs, perhaps over others in terms of just implementing these models.

And that may also vary by the model. So, for instance, to Carrie's point about the effectiveness in different clinical settings and clinical kind of areas of care, you can imagine that how we would design telehealth around a primary care model may be very different than a sub-specialty focused model anchored on hospitalization versus kind of a more global population-wide model.

So, I think there's a lot here and as we think about well, what is the potential with PFPMs, the kind of related question is what are the issues that really drift up to the surface as the most critical ones in each of these models that I think would be good for us, the Committee,

to think about?

CHAIR BAILET: Thank you, Josh. Other Committee members?

DR. COLLA: Just perhaps to slide us into the barrier section. I think the balance that we're thinking about is the balance between flexibility and lower administrative complexity, which was something we heard from the people who wrote in with the program integrity goals that Bruce brought up. And one of the things we've seen in the pandemic is this relaxation of the documentation and regulation around telehealth that's allowed it to blossom and be used in a lot of effective ways.

And so, thinking about how to balance those two things in the context of APMs is important.

CHAIR BAILET: Thanks, Carrie. I would like to add one of the challenges that I see as telehealth gets more embedded into clinical care delivery is the point disparities, particularly language, a language barrier.

And making sure that at the time of the visit that the appropriate translation services are available, and I think it's hit or miss.

It's clumsy at times, and what we don't want to do is have telehealth be built up in a way that really creates tremendous burden both on the patient and on the clinician.

So, I think that's going to have to be well thought through and how payment for those services gets baked into the model.

I hate to see where a translation service is obviously needed and it's mandated, but there's really no funding provided for it, which I think has been a challenge in the past for translation services.

So, I think that this an opportunity to sort of rethink that, and I'm hoping that as these models get incorporated with telehealth and telehealth gets launched more broadly, so that those considerations are thought about early on, rather than creating requirements around

translation services and then the lack of infrastructure support to ensure that those services are delivered appropriately.

DR. COLLA: Piggybacking on the disparity is also thinking about the types of clinical providers who are able to do these types of visits and including provider groups like community health workers could also help with the disparities issue.

CHAIR BAILET: Yes. And, Jay, I don't know if we're going to get to it in other segments but one of the things -- and if we are going to cover it in another segment, I'll leave it for then.

But I would like to spend a minute talking about the challenge with incorporating the data from a telehealth visit into the record rather than, I think we were advised from one of our stakeholder commenters in September that we want to avoid creating another silo for data, you know, to sort of sit in now the telehealth modules, if you will, and rather than the

electronic health record. So I'll look to you, Jay, if that's, if this is the right time to talk about that or you're going to cover it in one of your follow-on segments.

DR. FELDSTEIN: I think we cover it in one of the follow-on segments, but there's no reason we can't talk about it now because regardless of what we go through, it has to be addressed.

CHAIR BAILET: Yes, I guess the point I'm making is that it would really be, you know, shame on us if we push out telehealth and it just becomes another data sinkhole.

And it makes it even more burdensome for both the patients and for the physicians and all of the stakeholders to get access to this information to maximize its potential.

I think it could potentially be problematic if we don't really think about it and incorporate, purposefully incorporate how to avoid building out a system for telehealth that would basically -- inadvertently probably --

create a sinkhole for data. That would be a shame.

DR. FELDSTEIN: Yes, I think especially when you look at freestanding telehealth companies as compared to telehealth being offered as an integrated -- as part of an integrated delivery system -- where it's part of the service model in that integrated delivery system.

As opposed to freestanding telehealth companies that individual patients can access on an ad hoc basis. There are challenges in both of those universes.

So, I think from a policy standpoint, if we really don't address that upfront, we'll end up building probably a potentially larger silo than we've ever imagined.

VICE CHAIR CASALE: Yes, and I think this also adds to the prior conversation we just had around fragmentation of care and care coordination being, you know, flagged as really important as we think ahead around payment

models, you know, and telehealth has the opportunity to help with that potentially.

But as you're pointing out, if it's, where the data sits is going to certainly either exacerbate that fragmentation or potentially improve the coordination. So, being sure that that's part of the thinking around, from a policy point of view, I think is going to be important.

And on the disparities, you know, in addition to the language and other issues, one of the other challenges is just access to that specialty care often. And so, telehealth may be able to, you know, provide some additional access. It would be important.

But again, it has to be in a way that's integrated from a data point of view in order to effectively coordinate that care.

CHAIR BAILET: Thanks, Paul. Before we move on to the next segment, any other comments on this portion? All right, Jay.

DR. FELDSTEIN: Okay.

CHAIR BAILET: I'll turn it back.

DR. FELDSTEIN: Thanks, Jeff. Our second category is really, is barriers and enablers to accessing virtual care. So, you know, we need to have flexibility related to coverage and payment in the context of APMs and from an enabler's standpoint, consider research when enabling patient monitoring and other interventions as a form of telehealth. Next slide.

So, in terms of barriers, there's geographic limits, rural versus urban; state licensing represents a barrier to access; limitations on services covered, and site of care for virtual care represent a barrier to access. Currently there's been an easing of geographic restrictions and expansion of covered virtual services as due to our public health emergency. Provider shortage pose a barrier to access to care in urban and rural areas, especially around substance use disorders.

And there's a complexity and uncertainty in coverage for virtual care, which

unto themselves represent a potential barrier. And telephone or audio-only may be a necessary modality to ensure access for some populations. So, in the context of telehealth and APMs, we need to consider flexibilities related to geography, site of service, covered services, and provider state licensing. And where possible, seek to provide greater certainty regarding reimbursement and coverage policy for telehealth under APMs during and following the PHE[13]. Next slide.

Also, we need to look at chronic disease populations. They often view being symptomatic as part of their baseline or normal, and they may not seek virtual care that can help avoid hospitalizations or emergency department visits or adverse health outcomes. And telehealth which is not related to a virtual care event, such as remote patient monitoring, can provide proactive care, and these services are not addressed through temporary [Section] 1135

13 Public health emergency

PHE waivers.

So, in the context of new and existing APM models, we need to consider further research that can assess the potential of adopting remote patient monitoring and other forms of telehealth, either new or existing models not related to the existing temporary waivers during and after the PHE. Next slide.

So, these really barriers and enablers in terms of access and optimization, which we kind of alluded to before, I think, you know, warrant a lot of discussion. Not only from geography, specialty, and just integration of all these services that we talked about and not building silos. So, Jeff, back to you.

CHAIR BAILET: Thanks, Jay. I'll open it up to the Committee. Well, maybe I'll jump in, Jay, you know, when you talk about site of service, I think about the traditional visit in an exam room -- there's certain privacy and security elements that are incorporated and hardwired into that visit.

And I was thinking about, you know, when you're in a situation where it's a telehealth visit, the environment isn't necessarily controlled. And so, I think it's something that I'm sure is being looked at, but what are the parameters around protecting patient health information, making sure that the visit is secure?

When you're in an exam room with a patient, you know, obviously the patient knows whether someone else is in the room like a scribe or a nurse, assistant, et cetera. But that's not the case in a telehealth visit so, I'm just wondering have you guys, did you guys consider, or that certainly didn't come up amongst the stakeholders, and maybe that's something that we can save for the research side of this discussion.

But it is something that as it becomes more ubiquitous in clinical delivery, I'm wondering whether there needs to be some purposeful design around telehealth in protecting

the security of the information in those visits. What do you guys think about that?

DR. FELDSTEIN: Well, we looked at that in terms of a research question, and we address it somewhat when we talk about what are the, you know, appropriate guardrails. But I think we do need to be specific, you know, from a HIPAA[14] and cybersecurity standpoint as we move forward. This is going to be, you know, another data set that we're going to have to manage and protect.

CHAIR BAILET: Right.

MS. HARDIN: That's a great --

CHAIR BAILET: And I don't -- go ahead, I'm sorry. Go ahead.

MS. HARDIN: This is Lauran. That’s a great point, Jeff. And I think we didn't get really deep into that, but it's so important to think about privacy and confidentiality on both sides of the technology. One of the interesting things we've seen in the data across the country

14 Health Insurance Portability and Accountability Act

is there's actually been a very big uptake and response to people actually attending behavioral health telehealth visits as well as substance use disorders. So, some of the services have actually expanded access, but it also highlights and exacerbates and makes even more important the confidentiality question.

CHAIR BAILET: Right, yes. And again, I think this is a, I'm just calling it out, we're not going to solve it necessarily in our meeting today. But I do think it needs to be highlighted in our recommendation to the Secretary in our final letter.

DR. LIAO: This is Josh. I just had one other comment about the barriers. I was struck by kind of, and not another thing we're going to solve today. But I do think, you know, telehealth -- we kind of group a number of things together. What I heard from Jay and others is that, you know, there's audio-only, audio-video, and I think just an openness to kind of the idea that things may prove in certain settings to be

more useful than others and being willing to kind of focus on the ones that are most effective.

And so, the barriers will probably look different perhaps across that as the evidence comes out. And the other thing is, I think relevant to our Committee, is this idea of evaluation and the ability to be evaluated. And so, there's that tension, at least in my mind, around kind of there's a flexibility with which people deploy these and then the ability to kind of come to the other side and say did it work in some way? And I don't have answer, but I think we should keep that front and center when we think about the barriers.

CHAIR BAILET: Thanks, Josh. Carrie.

DR. COLLA: And building on that, in the privacy and confidentiality issues, I think, I mean, we're in the United States, we're focused on Medicare, but we're really in a multi-payer environment. And one of the problems we've seen in terms of APM diffusion is also around standard models across payers, and I think that is a

problem here too. When each payer has their own set of rules and regulations around telehealth, it really can inhibit expansion of these services.

And so, thinking about the importance of multi-payer alignment in these services and standards in terms of confidentiality and privacy in terms of the regulation. And then the other thing in terms of barriers and facilitators that struck me was really the importance of the state laws about licensure and parity, and how important they are in terms of the use of telehealth across different states. This is pre-pandemic -- now it's a little bit more similar.

CHAIR BAILET: Yes, great point.

MS. HARDIN: And, Jeff, I would just add one other point. This didn't necessarily come up in our meeting or in the comments, but what I've seen over the last few months is an explosion of hospital-at-home. Partially to deal with capacity and carry the COVID cases and really make a proactive system, but that's really

going to affect number two and the technology and monitoring that there are requests for -- really deep payment. Because I think that shift is going to be permanent.

CHAIR BAILET: Yes. I completely agree, Lauran, and that's going to be amplified. I don't see that going, I don't see that going down. I see that becoming more common practice. So, that's a great point.

VICE CHAIR CASALE: Yes, I wanted to --

CHAIR BAILET: Any other comments from the Committee --

VICE CHAIR CASALE: -- yes.

CHAIR BAILET: -- yes, go ahead, Paul.

VICE CHAIR CASALE: I was going to echo that point that Lauran just made. Also saying the shift to sort of care at home models and the explosion in remote patient monitoring and anything from wearables to, you know, in cardiology obviously, we've been monitoring, you

know, pacemakers and ICDs[15] and other devices. And understanding where it's a benefit and who's actually looking at the data, what's the infrastructure, and build a cost to monitor that data as it comes in?

And then using that effectively, whether, and then thinking through the models where that might be, you know, particularly beneficial. So, there's no question that I think it is beyond the pandemic here to stay. I think there's a lot, and I emphasize here around research and assessment that needs to be done to understand, you know, the effectiveness of each of those modalities within remote patient monitoring.

DR. WILER: I agree with Paul's comments and wanted to add that I think under a research agenda, that wasn't discussed here but just to surface it, are how do we not increase cost within the system? So, do we add human capital resources to help with this remote

15 Implantable cardioverter-defibrillators

monitoring at home, or are there software solutions like AI[16] algorithms that are helping to do this monitoring?

So, there needs to be some assessment of how do we not add cost to the system but actually, you know, improve value and ultimately expand services without, and doing it in a safe and effective way. And so, creating measurement of that process is really important from a safety and quality perspective. So, that could be another aspect of the research agenda.

And the last comment I would make is around this home-based care as a new care model and being mindful of thinking about how do we train the workforce to be able to do that. And making sure we have alignment with, not in the provider space or physician/provider space, GME[17] programs that actually train our future clinicians about how to deliver care in this way, would also be a separate and distinct but important research agenda.

16 Artificial intelligence
17 Graduate medical education

CHAIR BAILET: Great. Great point. I was just going to raise the issue of storage of all of this information that we're expanding, we're collecting, and more monitoring, to your point, Paul. You know, monitoring ICD devices and other devices that's going to continue to put a burden on the storage and gets back to my earlier point about security.

Where is this information going to sit, and how are we going to store it in a way that's going to be able to essentially expand as the information expands so that it's still accessible and it's still usable? And that's something that we probably should incorporate in our letter as well. Particularly security if it's not -- right now there's very robust security parameters around sort of the traditional electronic health record, and the visits, et cetera.

But I'm not so sure that's the case in the telehealth world as it expands and other vendors get into the space. Do they have the

same robustness in parameters around security and access, et cetera? I know that when you work in health systems, you know, you have auditing abilities to actually look at who's accessed the data and are they, do they have the appropriate permission rights to do that and there are recourses that can take place.

I'm not sure that all of that's being built-in in the telehealth universe. So, that's something to think about. All right. Any other comments before I turn it back to Jay? All right, Jay.

DR. FELDSTEIN: Okay. Let's move onto Category Three, which is payment issues, you know, and how do we, you know, to document our emerging findings, how do we use APMs to enable telehealth? And how do we leverage the insights from our previous PTAC proposals? Next slide.

So, some of our key observations in fact, were providers that are engaged in APMs, were able to adapt quickly and pivot to virtual care under the COVID-19 PHE. And that APM models

gave providers more flexibility sometimes through prospective and risk adjusted payments, which we had discussed early, to adopt to virtual care modalities.

And that we need to consider highlighting best practices and findings from rapid adoption of telehealth among providers involved in APMs across provider settings, and clinical scenarios, stand-alones, substance use disorders, or behavioral health, as well as the usual source of care -- and this kind of just dovetails to Josh's comments earlier. Next slide.

Virtual care delivered under APMs can be a tool to help ensure continuity of care, avoid exposure and avoidable utilization, ED[18] and inpatient, especially in a PHE environment, and support provider to provider coordination. Flexibility afforded through prospective payments and risk adjustment can support flexible adoption of virtual care modalities. And additional

18 Emergency department

evidence is needed regarding the impact of telehealth on cost, access, and quality for various services.

We need to consider including telehealth modalities across all APMs currently in testing or development as tools for facilitating access to care; optimizing care delivery; reducing avoidable inpatient or ED care; improving health outcomes; improving provider coordination; and supporting provider teaching, education, and collaboration. And we should consider using ACOs or other models to assist in testing the impact of telehealth on cost, access, and quality for various services. Next slide.

Now our 18 previous PTAC proposals included telehealth as a component of their models. Some of these proposals included innovative care delivery models related to providing remote assessment and education to rural providers, relating to neurological conditions, telemonitoring of patients with

chronic conditions, providing team-based care to multiple skilled nursing facilities, ensuring care coordination after discharge from EDs, and maximizing primary care provider flexibility.

ACOs' shared savings could potentially be used to support cost-saving telehealth interventions. So by reviewing previous PTAC proposals that included a telehealth component and incorporate some of the telehealth related elements from one or more of these proposals into ACOs and other CMMI models that include prospective payment and two-sided risk in order to pilot test potential best practices and assess their impact on health care costs and quality. Next slide.

So that really, you know, when we start to talk about payment issues, these were the key ones that came to light both on the discussions during our September 16th model, and I also think we've got additional comments from Lauran and Carrie on these as well.

MS. HARDIN: Thank you, Jay, this is

Lauran. I think one of the interesting things in this arena is especially in behavioral health. We've seen a tremendous drop in the no-show rate. And it also brings up with behavioral health and substance use disorder: what is a patient's usual site of care? So, often with those services they're seeing those providers many more times than their primary care physician. So, it starts to expand the dialogue about usual source of care, how that care is funded, and how the data is integrated.

CHAIR BAILET: Thanks, Lauran. Carrie, do you have a comment? Maybe I saw your hand go up, maybe it was a shadow, sorry about that.

DR. COLLA: No, not right now. Thanks, great job, Jay.

DR. FELDSTEIN: Jeff, or for additional PTAC conversation and discussion.

CHAIR BAILET: All right. Payment, this is a big issue. I'm happy to jump in but would love my colleagues to go first if there's

any comments here. Well, we touched on it earlier about, I think it was you, Jennifer, talked about all payer, and I think really that's going to be to some degree, the secret sauce here is to get commercial payers to partner with Medicare and create an intelligent framework for payment.

I think that the variability in payment now for telehealth services, and particularly when the pandemic washes out, it has the potential to be really problematic, and I think this is the opportunity, and my preference would be to get it right. And again, not saying that there can't be any flexibility or variation, but I do think it is the opportunity for the commercial payers to really think about how to pay for these services, what's incorporated, what's not. Some of the items that we've already touched on as it relates to elements like disparities and translation services, et cetera.

Not to get, not to revisit that, but I do think that the biggest barrier to uptake in

telehealth could be simply payment. And I think it could be a huge, compelling accelerant to further adoption. But it could it also be a huge detractor, and specifically you think about physicians and whether they're in small practices or big systems, there's a lot of infrastructure that has to get built to support telehealth. We talked about some of those items today, storage, security, et cetera. And it would be a shame to build that infrastructure, which is a long-term play and not have a payment methodology that really supports it.

And I'm not saying a reckless payment methodology. I think from a payer's perspective that's always been the question mark -- is, you know, how much control will they have on cost if telehealth sort of just gets, you know, becomes a free-swimming environment? And we're not suggesting that by the way, but that's, I think, one of the risks that the payers have been resistant -- even Medicare, to some degree, has been resistant on sort of -- and allowed them to

sort of govern the use of telehealth.

I think now is the time to understand the value of telehealth, the real value that it brings, avoiding emergency room visits, avoiding all of the pain points for patients who have limited opportunities for transportation. And being able, from a provider's standpoint, to be able to make those, get in those communications with patients and their caregivers -- more of a real time than trying to go through the scheduling and appointment morass that some folks have to struggle with.

So, if I could just back up, I really do think payment is as much of a barrier as it is an accelerant to telehealth adoption, and I think we need to get it right as best we can.

VICE CHAIR CASALE: Yes, Jeff, hi, this is Paul. Yes, I absolutely agree with that, and thinking back in several of the proposals that we reviewed that had sort of this baked in, just a few comments around payment. I think one of the challenges was in several of them, there

was the proposal for a prospective payment related to, you know, building the infrastructure and managing the telehealth.

But then when it came to the two-sided risk, it was often, it was on the specialty side, there was a reluctance to sort of think about total cost of care. It was often around the care related to that specific condition and reducing either ED visits, et cetera, around that specific condition. I think that's one opportunity to explore further is, I think there needs to be that prospective payment for all the reasons we've talked about to build the infrastructure and build, you know, the integration within the system so that it is coordinated and not fragmented. But then tied to, you know, value world to this, to a two-sided sort of total cost of care and think how that, more broadly how to do that. Again, with the challenges of engaging specific specialties but within that, I think it spans that whole discussion around fragmentation of care and care coordination -- and patients

don't just have one condition -- in order to really build a platform that will work.

CHAIR BAILET: Thanks, Paul. That's helpful. Any other --

DR. WILER: I want to agree with your --

CHAIR BAILET: Go ahead, Jen.

DR. WILER: -- Yes, this is Jennifer. Yes, I want to agree with the comments and just call out that currently there's a perverse incentive with our payment system that encourages care to be delivered on site so, both the technical component and the professional component. And in organizations, you know, where there is potentially not alignment, so, two parties involved in care, which is, you know, the process or relationship for many current, you know, health systems and provider groups, there is financial disincentive to not have facility-based care. And so, I think exactly to your point, not only the comments around, you know, multi-payer but site of service is also something to be

considered. And then your comments, I just want to reemphasize, around payment structure are particularly important. And so, we've got other payment models and programs == Meaningful Use is obviously one that comes to mind -- where there was acknowledgement that there's a big upfront infrastructure cost that's required, and then there was an alignment of incenting the development of basic infrastructure to get everyone sort of to jump from curve A to curve B around a new care model and delivery model. And so, I think the thought has to go to, and maybe if this prospective payment, which is right what we've seen a lot of stakeholders recommend in the models that we've seen going forward.

But that has to be addressed because I agree -- the payment model is what will keep from developing a patient-centered care model, which COVID has clearly shown that virtual care services are a patient-centered care model.

CHAIR BAILET: Yes. Thanks, Jennifer. Any other comments --

MS. HARDIN: And then just to build on --

CHAIR BAILET: Lauran, go ahead.

MS. HARDIN: This is Lauran. Just to build on what Jennifer said. And so, the dialogue also has been loud and advanced around who actually gets paid for the telehealth visit. So, as the care has rapidly disseminated into the community and the home, social workers, nurses, pharmacists, community health workers. There's inter-professional care and really determining who's best to do the visit and how does that fit in the payment model total cost of care. And the APMs help, but that question isn't going to go away. If we look at it through the patient's eyes about what they need and how do we efficiently and effectively deploy the technology?

CHAIR BAILET: Good point.

VICE CHAIR CASALE: And just adding on to Jennifer's point about the, you know, the payment differential. There's also payment

differential in the in-person visit where there's often other ancillary services that are provided, which provide additional payment into the system, which is not there in a telehealth visit. So, you know, again, just highlights some of these differentials on payment between virtual and in-person.

CHAIR BAILET: Thanks, Paul. Jay, we may toss it back to you for research.

DR. FELDSTEIN: Okay. All right, next slide. Well as with any robust discussion, we often end up with more questions than answers, and telehealth is no different. So, we've got a fair amount of research opportunities and questions based on infrastructure, beneficiary and provider needs, standards for adoption, and barriers and payment issues. So, we'll get right into it. Next slide.

Consider sponsoring a report on unintended consequences associated with widespread adoption and use of telehealth that addresses the exacerbation of disparities in care

for specific populations due to the digital divide, cognitive and physical impairments, LTSS[19] needs, and for those living in the community with limited caregiver support.

Now how can see the needs of these populations be addressed in the context of telehealth and APMs, and what features of an APM will or will not facilitate helping these populations benefit from access to telehealth? Next slide.

Consider research on unintended consequences of widespread telehealth use on populations, including those with impairments or those who require language translation and culturally competent education. How can the needs of these populations be addressed? What features of an APM will or will not facilitate helping these populations benefit from access to telehealth? Next.

In the context of APMs, you know, what types of partnerships with the diverse array of

19 Long-term services and supports

stakeholders, including providers and those representing beneficiaries, support the development of standards for telehealth adoption, including workflow, service integration, team-based approaches, shifting to a culture of routine access, and interoperability of data gathered in the context of telehealth? And what is known about the standards of care, quality, measurement, safety, and appropriateness in the context of virtual versus in-person care? And what are the best approaches for determining services where there should be payment parity between in-person and virtual care?

And how do we account for differences in the care environment and incentives inherent in virtual versus in-person care while also maintaining simplicity and flexibility? Which telehealth interventions are different modalities/settings rather than a new type of service, and are there program integrity challenges associated with telehealth? Next slide.

In the context of APMs, explore research on costs associated with beneficiary access to broadband connectivity, and technologies, and technical support needed to benefit from telehealth. How, if at all, should APMs incorporate cost of implementation and effective use of telehealth into their payment design? How do different APM payment designs facilitate or create barriers to effective adoption and use of telehealth? And what supports do beneficiaries receiving care through APMs need to most effectively benefit from telehealth? And how does beneficiary satisfaction vary for specific services delivered virtually versus in-person? Next slide.

In the context of new and existing APMs, consider further research that could assess the potential of adopting remote patient monitoring and other forms of telehealth not related to existing temporary waivers during or after the PHE. And how does the role of telehealth vary if the intervention is a

substitute for in-person care versus a complement or supplement to in-person care? And how should coverage and reimbursement rules vary for these different forms of telehealth? Next slide.

And consider highlighting the best practices and findings from rapid adoption of telehealth among providers involved in APMs across provider settings and clinical scenarios, whether standalone substance use disorder, behavioral health, as well as usual source of care. And what are the reasons for and against the inclusion of telehealth in different types of payment models? What are the best approaches to understanding the true cost of adopting different telehealth modalities? And what are the models of payment that will make these financial investments feasible? Next slide.

So, these are a lot of questions for us to take up, and I'm sure there's more that will come out of our active discussion of these areas. So, Jeff, I'll kick it back to you for our last go-around here.

CHAIR BAILET: All right, Jay, nice job. So, maybe Lauran, Carrie, you guys were Jay's partners in this, did you guys have any specific comments that you haven't already made, relative to this last item around research questions and gaps?

DR. COLLA: Just generally in terms of like silver linings of the pandemic, what an opportunity we have to learn about telehealth based on what's happened in the last nine months. So, I'm very interested to see, I think we'll know a lot more in the next year about telehealth than we do now.

CHAIR BAILET: Great.

MS. HARDIN: Agree with Carrie, and it was well covered by Jay.

CHAIR BAILET: Super. Bruce.

MR. STEINWALD: I guess I'm thinking of the pre-COVID world and how much do we already know. I accept that we'll know a lot more from the COVID experience, but let's say how integrated delivery systems have used telehealth

versus how that contrasts with how telehealth is rolled out in uncontrolled fee-for-service system. Do we have much information about that at present?

CHAIR BAILET: Anyone? Jay?

DR. FELDSTEIN: I don't know the answer to that question. I think we know the volumes have increased so dramatically that I think, you know, most things operated at a much lower volume pre-pandemic. So I don't think necessarily a lot of attention was paid to it. But obviously I think with the tremendous increase in volume and utilization, we're going to get a lot more answers in a lot faster time frame.

MS. HARDIN: And, Bruce, I think there was two drivers, so it's difficult to differentiate where it grew. So, people in APMs were really driven to control costs, and so rapidly building that into their service was really important. People who lost fee-for-service revenue from the lack of in-person visits

were equally driven to build it out very quickly so, I've seen a pretty broad swath growth across the country in both buckets.

MR. STEINWALD: Be patient is the answer, I guess.

CHAIR BAILET: Jay, I wanted to maybe just pivot a little bit, but it is still in the research category and that is related to, you know, education of medical students and residents on telehealth. You know, we have a very well and very thoughtfully designed system to train for medical education clinical staff. It's not just physicians and medical students but also all of the folks, all of the stakeholders that are in the pipeline for care delivery.

But when it comes to telehealth, I'm sure that there are opportunities for standardization. That was something that you raised earlier and education and also, some of the parameters around signing off. If residents and students are involved in telehealth visits, you know, how do we ensure that they're conducted

appropriately, that there's clinical oversight that's appropriate and all of that sort of factored in?

And then, how to charge for those particular services? Those are all complications that we struggle with as it relates to education in a traditional practice setting, and I think telehealth just adds another layer of complexity.

DR. FELDSTEIN: It definitely does, and the answer to your question is yes, yes, yes, and yes. In fact, you know, we're trying now as we rotate students through outpatient primary care centers, as part of their experience they're with their attending, and they're now doing virtual visits as opposed to in-person visits. And, you know, we're kind of taking them through the logistics, you know, of how do you operationalize it, what's a visit look like, you know, but again, building on the foundation of in-person first.

But a lot of medical, all medical schools had to switch to a virtual environment

for, you know, traditional first and second years, and the third year, clinical experience, many medical schools had to go to virtual for the third year. Because when the pandemic first started, the hospitals were short on PPE,[20] and they didn't really know how to handle it. So, a lot of third year medical students were kind of kicked out of the clinical setting from March to about July.

And all medical schools had to adapt to a virtual environment. So, it's kind of part of the process now, and we're trying to figure out, you know, how do we put the standards around it from an educational standpoint? And to Jennifer's comment earlier, I mean, the whole future of GME is going to be altered as more and more care is delivered out of the hospital. I mean, the hospitals are traditionally the delivery of graduate medical education from a residency standpoint.

But as more and more care is in the

20 Personal protective equipment

home or various settings, how do we address that from a residency training perspective and a funding perspective? So, you know, there's tremendous opportunity, but there's also tremendous challenges that are before us.

CHAIR BAILET: Agreed.

MS. HARDIN: I think, Jay, and, Jeff, another competency too is how to maximize efficiency in the visit and inter-professional integrated care. So, I've watched sites around the country -- how they organize that visit and integrate different disciplines, and how they're doing it well. That will become even more important in GME as well.

CHAIR BAILET: Thank you, Lauran.

VICE CHAIR CASALE: And, Jeff, this is Paul. This is maybe a tangential comment, but I'm thinking about the Cures Act and the move to greater transparency around notes, and so you can imagine going forward in this world where the notes are now, you know, the encounters will

create notes that are, patients will have access to. And so, it'll be another impetus to thinking how best to coordinate care as well.

CHAIR BAILET: Yes.

DR. FELDSTEIN: You know, the only thing I would add, Jeff, is I think from a research perspective, we really need to incorporate what you brought up earlier in terms of cybersecurity and data storage. And how to protect this arena as it just, you know, grows exponentially over the next two to three years.

CHAIR BAILET: Yes. So, we'll definitely bookmark that. I thought maybe where you were going to go, Jay, is the outcomes, you know, how do we measure -- there needs to be some standardized approaches to measure outcomes of the effectiveness of telehealth on all of the disease states.

There's a lot we don't know about, about how effective telehealth is. We have some good ideas in some areas, but then there are long-term, you know, because of its uptake in the

last year, there's some long-term outcomes that are still unclear.

And I think that that needs to, I'm sure it's already being looked at, how effective telehealth can be. Not only on the cost side but also on driving quality results and reaching a lot more folks. So, I think there's a lot of research that's going to come out to really explore outcomes over time.

DR. FELDSTEIN: Agreed.

DR. LIAO: This is Josh. I would just build on Jeff's point and say that I think, you know, as I reflect on what Jay was sharing about how students and trainees are, you know, they're having to kind of implement and learn these kind of tele-visits. It strikes me that even before, maybe in the surge related to the pandemic, that there was variation in how different attendings and clinicians delivered care, make that double, triply so in the world of telehealth.

And so, I think without those outcomes, Jeff, it's very hard to, I think for

learners to say is this just variation between, you know, supervisor A and B, or is their outcome to say, it quote, ought to be done that way. I think that's going to be really critical if we're serious about this research thing that we've been talking about for the last 10 minutes.

CHAIR BAILET: Well, I think we should be serious about it. Reason is the cost. I mean, the expanse of a use of telehealth going forward and even baking it in to payment models, we need to know how best to deploy it to maximize its potential and effectiveness.

So, that's definitely something that I'm hoping we as a, you know, a system, a health care system, figure out sooner rather than later. Getting underneath outcomes has historically been one of the foibles for our health care system and so, I hope that it doesn't take as long on the telehealth side as it has for traditional practice.

VICE CHAIR CASALE: But I think we have to also recognize, it's often not a direct

line between, you know, like a telehealth and an outcome, right. Just like, you know, we know care management is good but, you know, the direct line between care management and outcomes, for years, lots of research is mixed. So, it's going to be difficult. But to reemphasize the cost piece and the payment piece and how to tie that to maybe more global outcome, I think we would require more research and also, thinking about how to get there.

CHAIR BAILET: Agreed. So, Jay, Carrie, Lauran, really, really nice job. You guys took in a tremendous amount of information, had to distill quite a bit. And I appreciate the fact that you've been able to present it to us to spark the conversation that we just had that's going to help us provide insights to the Secretary in a way that hopefully will be very valuable.

*** Instructions on the Report to the Secretary**

Before we wrap up this section, I'd

like to ask Audrey, who's been listening intently to our comments, if she could provide a brief summary on some of the key points of our discussion before we close out this section and move on to the public comment section of our public meeting today. Audrey. You might be on mute, Audrey.

MS. MCDOWELL: Yes, sorry about that, I had to unmute myself. So, I'm going to give you a summary of what I heard, and this will hopefully provide a basis for the information that will be included in the report to the Secretary. So, in terms of overall comments, it sounds like the Committee believes that telehealth, which includes a variety of different services and modalities, can be an important and effective tool for optimizing the delivery of health care.

And also, that the increased use of telehealth during the public health emergency provides an important opportunity that can be leveraged to hopefully increase the role of

telehealth and the delivery of value-based health care where appropriate. With regard to the challenges that need to be addressed in the context of telehealth, there are a number of challenges that the Committee has identified.

These range from barriers that have affected beneficiaries' access to and ability to use technology relating to telehealth; issues specifically relating to vulnerable populations; the need to develop standards and best practices and quality measures for telehealth; the importance of understanding the actual cost of providing telehealth services, which is important for being able to develop appropriate payments; the need to, as well, address issues related to coverage of telehealth such as which providers should be covered; and issues related to site of service and things of that nature.

Additionally, challenges that were raised in the discussion also include the tensions between increasing access and program integrity concerns; determining the efficacy of

telehealth across services; also, the balance between providing flexibility and administrative complexity; and also there was a lot of discussion about the upfront and infrastructure cost related to telehealth and the variability in payment.

So, in addition to the specific comments that were included in the PCDT's presentation, the report to the Secretary will synthesize specific comments that were made as part of this discussion. And in particular, the Committee members discussed the potential role that APMs with prospective payment mechanisms can play in giving providers flexibility to use telehealth effectively.

Also, testing the impact of telehealth on cost, access, and quality for various services and ensuring that telehealth is not overused. We also heard discussion about the importance of understanding which issues may be more relevant for different kinds of models in the context of APMs, such as primary care versus specialty

models.

The importance of addressing disparities, including disparities related to language, and ensuring that the cost of addressing these disparities such as translation services are included in the payment up front.

Additionally, discussion around the types of providers that should be providing telehealth services. One example was mentioning perhaps community health workers. The importance of improving care coordination, avoiding fragmentation of care, and avoiding creating another data silo related to telehealth. The importance of protecting patient health information. A lot of discussion around that. The importance of evaluating which modalities are most effective in addressing some of the specific barriers that have been identified.

Implications of the increase in the use of hospital-at-home models and remote patient monitoring. And the need for research on effectiveness and strategies for not increasing

cost with the use of these services. Additionally, discussion around developing appropriate payment models for telehealth and reducing variability across payers. And finally, the importance of getting information on telehealth outcomes, which also has implications for cost of these services.

So those are some of the major themes, but staff will also be reviewing the transcript and incorporating all of the, you know, the rich discussion that we heard during this deliberation. I think you're on --

DR. FELDSTEIN: Jeff, you're on mute.

CHAIR BAILET: Okay, thanks, Audrey, for that great summary. I'm glad you're able to keep up with us. That was very helpful. Appreciate all your support. We are going to close out this session. Any final comments from the Committee before we move on to the public comment section of our meeting today?

DR. COLLA: No. I just wanted to say thanks, Audrey, for getting that all down and

also for all of the work by ASPE and NORC leading up to this. Jay, you did a great job presenting it, and they did a great job coalescing it, thank you.

MS. HARDIN: Agreed.

CHAIR BAILET: Completely agree, wholeheartedly.

DR. FELDSTEIN: Thanks, everybody.

*** Public Comments**

CHAIR BAILET: You're a rock star, Jay. So, we're going to move into the public comment section. We have three folks signed up. They each have three minutes. I'm going to go ahead and introduce them, and the lines will be open. We're going to start with a former PTAC member, Harold Miller, who's the President and CEO for the Center for Healthcare Quality and Payment Reform. Welcome, Harold.

MR. MILLER: Thanks, Jeff, it's nice to with you and hello, everybody. Congress created PTAC for one very specific reason, to increase the number of physician-focused payment

models in the Medicare program. PTAC has failed to achieve that goal since none of the models recommended by PTAC have been implemented by CMS[21]. In most respects, the process established by Congress worked extremely well. Dozens of physicians in specialty societies developed excellent proposals for payment models that would improve the quality of care and reduce Medicare spending, and PTAC recommended 17 of those models for testing or implementation. However, despite that huge investment of time and effort by both the applicants and the members of PTAC, CMS has refused to implement any of the models that PTAC recommended. This is not because CMS found better ways to implement physician-focused payment models. Five years after the passage of MACRA,[22] most physicians in the country are still unable to participate in an Alternative Payment Model. This includes both primary care physicians and specialists. Moreover, the APMs that CMS has implemented have been failures. None of the

21 Centers for Medicare & Medicaid Services
22 Medicare Access and CHIP Reauthorization Act of 2015

Innovation Center models have resulted in net savings, and the Medicare Shared Savings Program has only managed to reduce spending by less than one percent after seven years of trying.

A major reason the CMS APMs have failed is because they are not physician-focused. Unlike the models PTAC has recommended, CMS APMs have not addressed the problems in the fee-for-service system that prevents the delivery of high-value care. Increasing the level of financial risk in bad models will make them worse not better.

Because it is now clear that CMS ignores all recommendations from PTAC, no one is even submitting proposals to PTAC anymore. It has been more than nine months since PTAC received its last proposal. The people who should be most concerned about this are the members of PTAC, yet you have remained silent about the problem. Over the course of a two-hour meeting this morning, there has been no discussion about the failure to implement PTAC

recommendations or what should be done to address it.

As the saying goes, silence implies consent. PTAC was not created to serve as a forum for stakeholders to convey their ideas and concerns, as you have suggested in your vision statement. Congress created PTAC in order to increase the number of physician-focused APMs. So, if you really want to achieve that goal, I recommend you do two things. First, you should begin providing data and technical assistance that will help stakeholders develop more and better physician-focused APMs. Most of the comment letters you receive ask for this, and you have $5 million in annual funding to support it.

When I served on PTAC, we tried to do this, but HHS lawyers said PTAC had no authority to do anything other than review proposals. Apparently that restriction no longer applies, however, since PTAC has spent the past six months talking about telehealth issues that have nothing to do with actual proposals. If HHS continued to

prevent you from providing data and assistance to stakeholders, you need to speak out publicly about the problem.

Second, you should ask Congress to change the law so that CMS is required to implement the models that PTAC recommends. Over the past nine months, CMS has implemented many major changes in payments and new Alternative Payment Models. This makes it very clear that the failure to implement the models PTAC has recommended is a lack of willingness by CMS to do so, not a lack of resources or ability. Only Congress can change that, and the members of PTAC need to publicly support that change.

CHAIR BAILET: Thank you, Harold. The next public commenter is, Dr. Eitan Sobel.

DR. SOBEL: My comments are on the financial aspect and the technology aspect of telehealth. Those ideas are outlined in my PTAC proposal of 2019 and 2020, and I will be happy to explain them in great details outside of this venue. Telehealth could turn out to be very

expensive. For years, insurance payers were concerned about overutilization of telehealth delivering high volume of low-value care. Nowadays, the pandemic has made telehealth popular.

It is about safety, and therefore, telehealth is here to stay. But it does not have to be a money pit business. Efficient telehealth could deliver great care and dramatically cut costs. So, what is efficient telehealth? Efficient telehealth is done in the setting of a medical team. Everything is one body without duplication of care.

For example, physical examination could be performed by one member of the team. Efficient telehealth cuts unnecessary transitions of care and eliminates unnecessary steps of transition. Efficient telehealth allows continuation of care regardless of location, and therefore, team members will provide care after the transition. In essence, condition of care will become in part, continuation of care.

It will be efficient and less expensive. The team approach to telehealth requires integrated technology. So, what is integrated technology? Integrated technology provides roads and bridges for information and communication. We have unique opportunity to correct our mistakes of the EMR[23] implementation era. Integrated technology will be owned and shared by all of us and will promote vertical thinking, allowing care of multiple patients, as opposed to the horizontal thinking of the current EMRs.

Integrated technology will open the market for competition. Competition reduces monopolism, increases patient choice, promotes better care and efficient care. Integrated technology allows innovative, new coordination of care mechanisms and new payment models. Those ideas are independent of our debate about single payer versus multiple payers.

In my PTAC proposal, I speak about

23 Electronic medical record

Regional Referral Centers or RRCs as a tool to decrease costs and promote competition, which you are welcome to read about. To summarize, efficient health care and integrated technology could be the keys for better care, enormous cost savings, and avoiding the money pit business of telehealth. Thank you.

CHAIR BAILET: Thank you, Dr. Sobel. And finally, we have Dr. Larry Kosinski, the Chief Medical Officer of SonarMD. Larry. Are you with us, Larry?

OPERATOR: Make sure you're unmuted, Dr. Kosinski.

CHAIR BAILET: Operator, is Larry on the line?

OPERATOR: Yes, he doesn't seem to be responding. He's unmuted.

*** Closing Remarks**

CHAIR BAILET: Okay. All right. Well, I want to thank everyone for participating today, members of the public, as well as my colleagues on the Committee. We explored many

different facets of telehealth and also laid down some of the groundwork for future changes to come. You can keep an eye out for the resulting reports and any other announcements by joining the PTAC listserv available at the ASPE PTAC website.

I want to thank you all for taking time out of your busy schedule to join us today. Please take care, be well, be safe. And the purpose of today, the meeting is adjourned.

(Whereupon, the above-entitled matter went off the record at 11:57 a.m.)

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

Before: PTAC

Date: 12-08-20

Place: virtual meeting

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