THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAY 12 2020

Jeffrey Bailet, MD
Chair
Physician-Focused Payment Model Technical Advisory Committee
200 Independence Ave SW
Room 415 F
Washington, DC 20201

Dear Chairman Bailet:

I appreciate the role that the Physician-Focused Payment Model Technical Advisory Committee (PTAC) plays in supporting the Department of Health and Human Services' (HHS) commitment to improving health care delivery, lowering costs and improving the quality of care for Medicare beneficiaries. As HHS continues to strive for value-based health care transformation, I encourage new ideas for proposed physician-focused payment models (PFPMs) that address the health care needs of Americans. I am pleased to respond to the comments and recommendations of the PTAC for the proposed model voted on during the September 2019 public meeting.[1] The PTAC's robust discussion of proposed physician-focused payment models (PFPMs) helps guide our efforts to develop innovative payment and service delivery models.

Building on proposed PFPMs, the PTAC's comments, and previous Centers for Medicare & Medicaid Services (CMS) model experiences, we are designing and testing paying for health outcomes rather than procedures on a much larger scale than ever before. The CMS Center for Medicare and Medicaid Innovation (CMS Innovation Center) has worked to take into account unique needs of rural communities with alternative payment models and value-based payment arrangements. For example, rural accountable care organizations (ACOs) with a smaller population of patients can participate in the Next Generation ACO Model that is testing financial incentives to improve health outcomes and lower expenditures for Medicare beneficiaries. Additionally, the CMS Innovation Center's Emergency Triage, Treat, and Transport Model allows ambulance care teams serving Medicare beneficiaries greater flexibility to find appropriate places for treatment that may not always be a hospital. Especially in rural areas, this helps people obtain more convenient access to services and care without expensive, avoidable transports to a hospital emergency department. The PTAC's expert analyses, discussions, and recommendations of proposed PFPMs help the CMS Innovation Center distill innovative payment and service delivery model concepts that can contribute to health care reform.

[1] This response and accompanying documents comprise the Secretary's detailed response to PTAC comments and recommendations, posted on the CMS website, in accordance with the statutory requirement at §1868(c)(2)(D) of the Social Security Act.

I look forward to working further with the PTAC, those who submit proposed PFPMs, and other stakeholders as we all move toward a value-driven delivery system. I hope that my responses to the most recent PTAC comments and recommendations (see Appendix) encourage and assist those who submit proposed PFPMs in the future as they advance transformative innovation in American health care.

Sincerely,

Alex M. Azar II

Enclosure: Appendix

Appendix

This appendix contains the response from the HHS Secretary to the PTAC comments and recommendation on the PFPM proposal from the University of New Mexico Health Sciences Center.

University of New Mexico Health Sciences Center

I appreciate the University of New Mexico Health Sciences Center's (UNMHSC) proposal submitted to the Physician-Focused Payment Model Technical Advisory Committee's (PTAC). I value the PTAC's review of the *ACCESS Telemedicine: An Alternative Healthcare Delivery Model for Rural Cerebral Emergencies (ACCESS Telemedicine)* proposal and its robust discussion of the proposed model during the September 2019 public meeting. The PTAC's significant comments and recommendations will help guide our efforts to develop innovative payment and service delivery models that better address the challenges of providing access to specialty care in rural areas.

The goal of the proposed model is to meet an, identified need for cerebral emergent care in rural areas where there is a shortage of neurologists and limited financial resources in rural hospitals. ACCESS Telemedicine would increase consultation opportunities for specialists, and broaden the scope of telemedicine provided to patients with neurological conditions by rural hospitals and their affiliated clinicians.

The proposed model is based on the UNMHSC's ACCESS Telemedicine program, which was supported through the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation's (CMS Innovation Center) Health Care Innovation Awards Round 2 (HCIA-2) cooperative agreement from 2014 to 2017. Under the ACCESS Telemedicine program, when a patient presents in a participating spoke hospital's emergency department (ED) with a neuro-emergent condition, the ED physician uses the Net Medical Express Solutions (NMXS) telehealth platform to communicate with a neurologist or neurosurgeon. These specialists, contracted by either NMXS or UNMHSC, examine the patient, review imaging, and discuss treatment options through the technology's secure file transfer and video capabilities. Based on the consultation findings, the patient is either discharged, admitted, or transferred. Telehealth coordinators located at each participating hospital facilitate the consultation process and serve as the primary liaison between ACCESS and ED staff at participating hospitals.

The Evaluation of the Round Two Health Care Innovation Awards {HCIA R2): Third Annual Report[1] described UNMHSC's challenges with enrollment, serving 74 percent of its target population through the ACCESS Telemedicine program. Not as many hospitals joined the program as anticipated because of concerns they could not cover the costs of the consultations for privately insured or uninsured individuals or after the cooperative agreement ended. In addition, lengthy specialist credentialing processes and staff turnover in participating hospitals negatively affected the number of consultations performed. Hospitals reported the telehealth process was straightforward and the technology easy to use, which was credited to UNMHSC's partnership with NMXS for the development and management of the telehealth platform. Hospitals also reported that the program helped them provide patients with timelier access to specialty care, improving patient outcomes and reducing transfers, which can be costly to insurers and disruptive for patients and their families. UNMHSC did not develop a new payment model for its ACCESS Telemedicine program, but instead identified a payment approach for neurological and neurosurgery telehealth services under existing Medicare FFS payment.

[1] https://downloads.cms.gov/files/cmmi/hcia2-yr3evalrpt.pdf

The proposed model would allow a hospital that serves as the originating site to bill for and receive a bundled payment when using neurology or neurosurgery telehealth consults from distant site practitioners. The bundled payment is designed to cover the cost of the consultation by the physician, the cost of the telehealth technology, the cost incurred by the entity providing consult services to ensure availability of consulting clinicians, the provision of education to local staff, and quality assurance.

I agree with the PTAC that improving access in rural areas to specialty care, such as for neurological emergencies like suspected strokes and head injuries, is an important goal. I also agree that several aspects of the proposed ACCESS Telemedicine model would require development or revision of quality measures, performance targets, and the payment model. Further, a potential payment and service delivery model would need to consider the high cost of delivering services for cerebral emergencies, particularly the underlying technology platform costs.

I am interested in exploring how the concepts in the ACCESS Telemedicine proposed model could be incorporated into payment and service delivery models in development at the CMS Innovation Center. I have asked the CMS Innovation Center to reach out to the submitters for further discussion on how key mechanisms of action in this proposed model could be reflected in innovative payment and service delivery models involving rural health.

I want to thank UNMHSC for your continued engagement with the CMS Innovation Center and helping to drive transformative innovation in American health care. I also want to thank the PTAC for its critical review of this proposed model.