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ANNUAL MEETING AND PUBLIC POLICY FORUM

NOVEMBER 5-6 2020

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COVID-19 and the Future of Health Care Delivery and Payment

Moderator: Julia Lerche, Chair, Academy Medicaid Subcommittee

Panelists:

- **Dr. Mark McClellan**, Director, Duke-Margolis Center for Health Policy, Robert J. Margolis MD Professor of Business, Medicine and Policy
- **Dr. Ateev Mehrotra**, Associate Professor of Health Care Policy – Harvard Medical School; Hospitalist – Beth Israel Deaconess Medical Center
- **Dr. A. Mark Fendrick**, Director, Center for Value-Based Insurance Design, University of Michigan
- **Dr. Adaeze Enekwechi**, Former President, IMPAQ

Dr. Mark McClellan Presentation

Future of Health Care Delivery and Payment

Mark McClellan MD PhD

Robert J. Margolis, MD, Center for Health Policy

November 6, 2020

Unprecedented Initial Impact of COVID-19 on the U.S. Health Care System

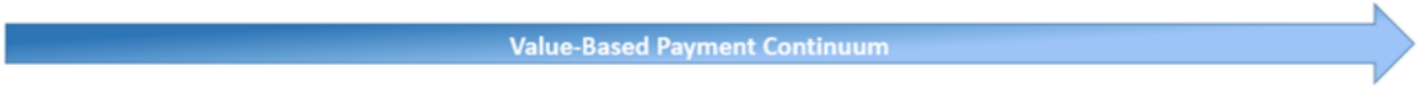
Utilization decline – Large initial declines in outpatient and inpatient utilization (up to 60%); most care has rebounded, now averaging about 10% less than normal

Steep financial cost – AHA estimated Hospitals and health systems to lose > $300 billion in 2020, hospitals' margins will be -7% in the second half of 2020 without further relief funding; medical practices have even larger losses

Workforce impact – Health care sector lost 1.4 million jobs in April, not yet achieved a full recovery; high risk of COVID-19 among front-line workers

Significant Federal financial assistance – Over $200 billion in direct payments and loans approved by Congress so far – mostly to hospitals

COVID-19 has impacted providers differently in value-based payment vs. fee-for-service

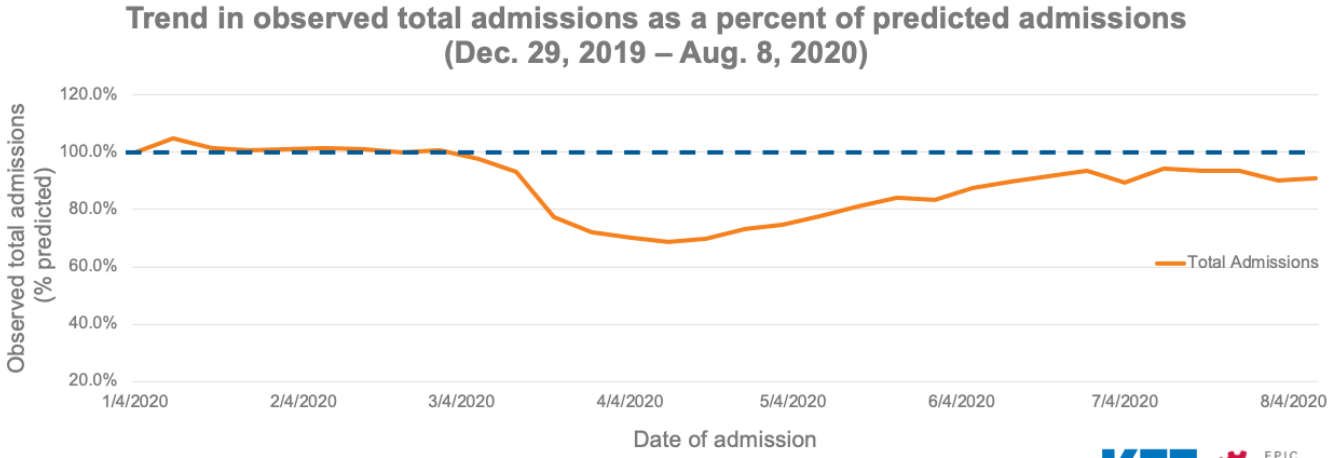


	Fee for Service (FFS)	FFS with Shared Savings	Limited Prospective Payment	Primarily Prospective Payment
Revenue Change	Significant drop in revenue triggers staff reductions, practice closures	Small shared savings backstop offers limited protection for staff reductions, fewer closures	Prospective payments guarantee small revenue stream, less drastic reductions	More stable revenue streams allowing for continued and expanded service delivery
Financial Stability	Direct financial assistance needed to maintain operations	Benefits from shared savings leads to smaller but still necessary need for financial assistance	Benefits from prospective payment leads to smaller but still necessary need for financial assistance	Most payments delinked from FFS means significantly higher stability
Flexibility for Care Reform	Requires financial assistance for COVID-19 response	Limited; Can support some investments in COVID-19 response, but more assistance required	Greater capacity than shared savings to support investments in COVID-19 response	Supports most key investments in COVID-19 response

Source:
https://healthpolicy.duke.edu/sites/default/files/atoms/files/best_practices_brief_final.pdf

What's happened for FFS Providers? Part 1…

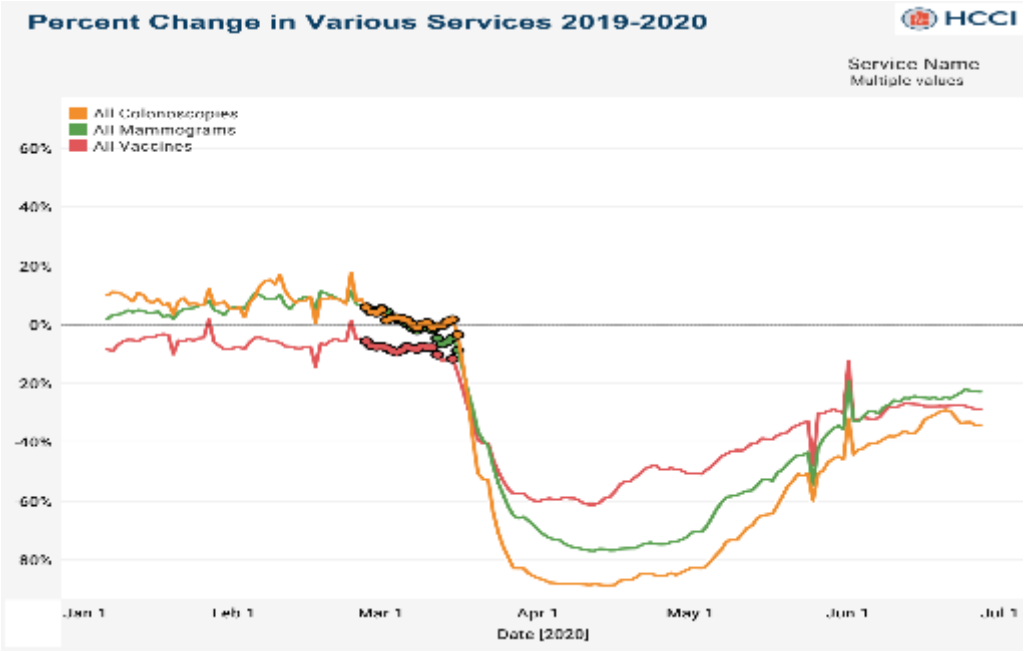
Overall Admissions Decreased in March and April but Were Back at About 95% of Predicted Admissions by July 2020



SOURCE: Epic and KFF analysis of Epic Health Record System COVID-19 related data as of September 2020.

KFF HENRY J KAISER FAMILY FOUNDATION
EPIC HEALTH RESEARCH NETWORK

What's happened for FFS Providers? Part 2…



Source: https://healthcostinstitute.org/hcci-research/the-impact-of-covid-19-on-the-use-of-preventive-health-care

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Care Reforms for COVID-19 and Beyond

Advanced primary care teams, with enhanced capabilities (including virtual care) and data support

Increased access to virtual behavioral health services, integrated with primary care

Enhanced home and virtual care models for specialized conditions – for example, end-stage renal disease (home dialysis), cancer (home drug infusion and complication management), complex patients (home rehabilitation and “hospital at home”)

Increased attention to social isolation, mental health, hunger, and other social determinants of health

Not restarting low-value care – redirecting resources to implement alternative patient management approaches

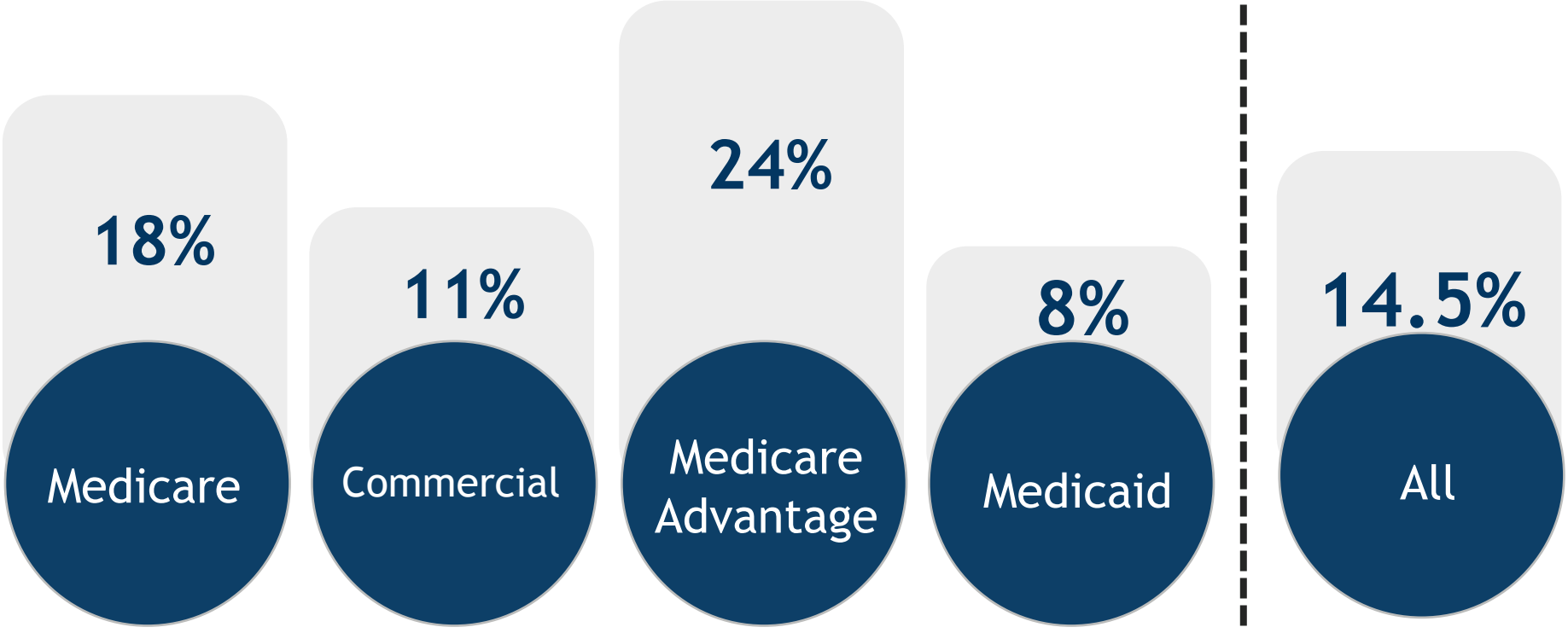
Public health integration – assistance with testing, tracing, and isolation support

New Or Enhanced Capabilities Needed to Support Care Models – Hard to Sustain Under FFS

Organizations are using upfront payments, capital, or partnerships in value-based models to develop or enhance the necessary capabilities and succeed in them, such as:

- Establishing telehealth, remote monitoring, and patient engagement app platforms to improve virtual care capabilities
- Trained workforce to support care coordination and address social needs
- Building robust data systems for population health management and identifying high-risk individuals
- Building capacity for home- and community-based delivery of primary care, mental health, and specialized care needs

Only a Minority of Health Care Payments Had Significantly Shifted from Fee-for-Service to Downside/Capitated Payments Prior To COVID-19 (2019 Survey)



HCP-LAN. 2019 APM Measurement Effort. Oct 2019. Share of payments in "advanced" alternative payment models (LAN categories 3B and 4).

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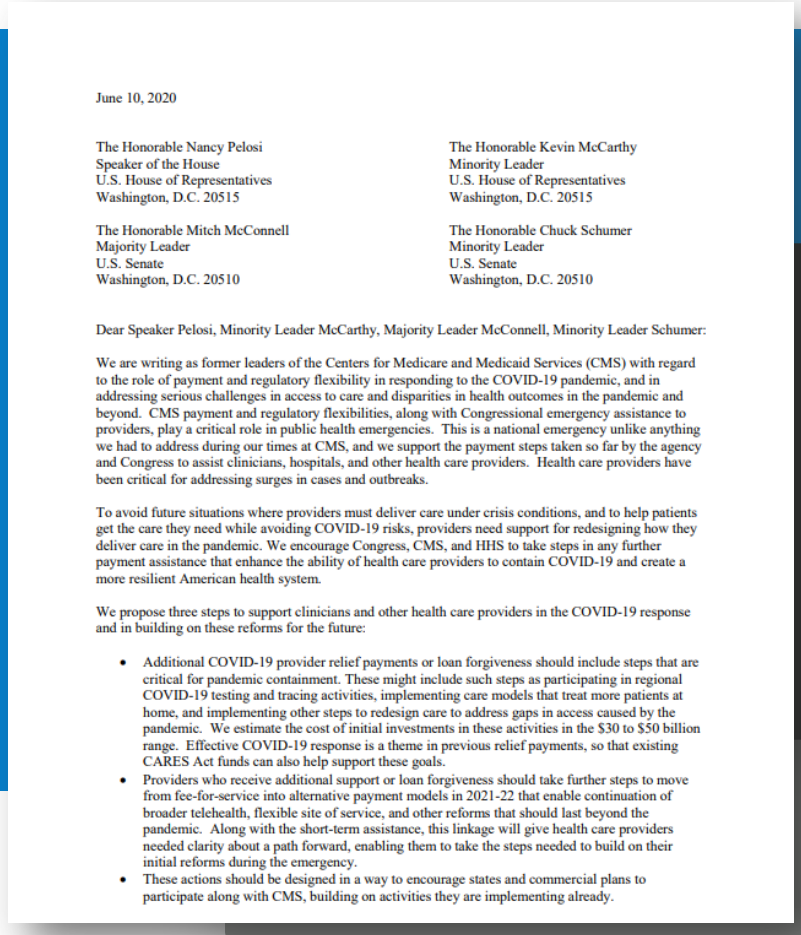

June 10, 2020

The Honorable Nancy Pelosi
Speaker of the House
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Kevin McCarthy
Minority Leader
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Mitch McConnell
Majority Leader
U.S. Senate
Washington, D.C. 20510

The Honorable Chuck Schumer
Minority Leader
U.S. Senate
Washington, D.C. 20510

Dear Speaker Pelosi, Minority Leader McCarthy, Majority Leader McConnell, Minority Leader Schumer:

We are writing as former leaders of the Centers for Medicare and Medicaid Services (CMS) with regard to the role of payment and regulatory flexibility in responding to the COVID-19 pandemic, and in addressing serious challenges in access to care and disparities in health outcomes in the pandemic and beyond. CMS payment and regulatory flexibilities, along with Congressional emergency assistance to providers, play a critical role in public health emergencies. This is a national emergency unlike anything we had to address during our times at CMS, and we support the payment steps taken so far by the agency and Congress to assist clinicians, hospitals, and other health care providers. Health care providers have been critical for addressing surges in cases and outbreaks.

To avoid future situations where providers must deliver care under crisis conditions, and to help patients get the care they need while avoiding COVID-19 risks, providers need support for redesigning how they deliver care in the pandemic. We encourage Congress, CMS, and HHS to take steps in any further payment assistance that enhance the ability of health care providers to contain COVID-19 and create a more resilient American health system.

We propose three steps to support clinicians and other health care providers in the COVID-19 response and in building on these reforms for the future:

- Additional COVID-19 provider relief payments or loan forgiveness should include steps that are critical for pandemic containment. These might include such steps as participating in regional COVID-19 testing and tracing activities, implementing care models that treat more patients at home, and implementing other steps to redesign care to address gaps in access caused by the pandemic. We estimate the cost of initial investments in these activities in the $30 to $50 billion range. Effective COVID-19 response is a theme in previous relief payments, so that existing CARES Act funds can also help support these goals.
- Providers who receive additional support or loan forgiveness should take further steps to move from fee-for-service into alternative payment models in 2021-22 that enable continuation of broader telehealth, flexible site of service, and other reforms that should last beyond the pandemic. Along with the short-term assistance, this linkage will give health care providers needed clarity about a path forward, enabling them to take the steps needed to build on their initial reforms during the emergency.
- These actions should be designed in a way to encourage states and commercial plans to participate along with CMS, building on activities they are implementing already.

Former Administrator Letter
June 10, 2020

"We encourage Congress, CMS, and HHS to take steps in any further payment assistance that enhance the ability of health care providers to contain COVID-19 and create a more resilient American health system."

Mark McClellan, Andy Slavitt, Don Berwick,
Tom Scully, Bruce Vladeck, and Gail Wilensky

https://healthpolicy.duke.edu/sites/default/files/2020-06/cms_resilience_letter_final.pdf

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COVID-19 Payment Reforms and Health Care Resilience

	Now: Non-FFS Resilience Payment		2021-2023: Implement Alternative Payment Model
Medical Practices	• COVID-19 testing, data sharing, and containment activities • Telehealth and remote monitoring to support home and community-based care	⇨	**Potential APM Options: Advanced Medical Home, Direct Contracting, Physician-led ACO** • Continued telehealth, site of service, and care team flexibilities to facilitate transition into an APM • Continued population health management activities
Hospital-Based Systems	• COVID-19 testing, data sharing, and containment activities • Resources to treat COVID patients • Resources to modify staffing and workflows to limit exposure risks	⇨	**Potential APM Options: Direct Contracting, Partial-Capitation Accountable Care Organization, Broader Bundled Payments, Global Budgets for Rural Hospitals** • Continued telehealth, site of service, and care team flexibilities to facilitate transition into an APM • Enhanced telehealth services to support delivering symptom management and other check-ins from home

https://healthpolicy.duke.edu/sites/default/files/2020-07/Resilience%20Proposal_073020FINALWeb.pdf

Alternatives for Supporting Care Integration

Model	United States Examples	Pros	Cons
Primary Care ACOs and Accountable Specialty Groups	Commonwealth ACO (Arizona) Comprehensive ESRD Care Organization	• Core providers, close to patients • Can build out incrementally • Relatively large benefits from successful reforms-incentives to shift	• Lack of scale and capital to develop competencies and infrastructure
Hospital/System-Based ACOs	Duke Health (Durham)	• Significant capital availability • Engagement of specialized care • Can address patient concerns about reduced access to specialists/ intensive services	• May be reluctant to move to truly value-based care and payment models—more to lose • Provider consolidation—market power may lead to higher prices or less efficiency
Accountable Health Insurer	Caremore Alignment Health Care	• Capital availability • Useful data/analytics and ability to align patient benefits	• Must build out provider integration, coordination, and support
Accountable Care Enabler	Aledade Health Optum CityBlock	• Capital through investors • Provide add-on capabilities and some risk sharing • Can scale solution to key care gaps	• Limited provider integration • Additional entity to involve in coordination

Steps for Employers

Employers are crucial to supporting these efforts, as the majority of Americans are commercially insured, and can support LVC reduction efforts by:

- Shifting to Total Cost of Care and Health Impact analysis for assessing payers
- “Centers of Excellence” programs
- Direct contracting
- Benefit designs that support the use of high-value care networks

Steps for Patients

Patients need to be engaged in value-based care initiatives, through strategies such as:

- Patient engagement initiatives
- Transparent, meaningful quality and cost information
- Value-based benefit design

Steps for Policymakers

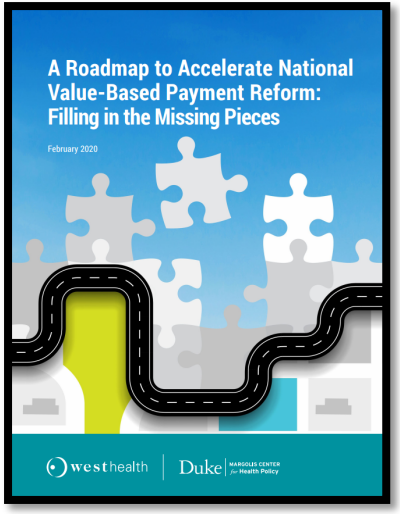
Policymakers should consider further COVID-19 relief initiatives through the lens of health care resilience – not returning to the ”old normal”:

- Continue current emergency flexibilities (telehealth, site of service, scope of practice and benefits) – more extensively in advanced payment reforms
- Link relief payments to COVID-19 response assistance and longer-term, predictable shifts toward value-based payment models
- Include steps to address public health and social drivers of poor outcomes and high costs

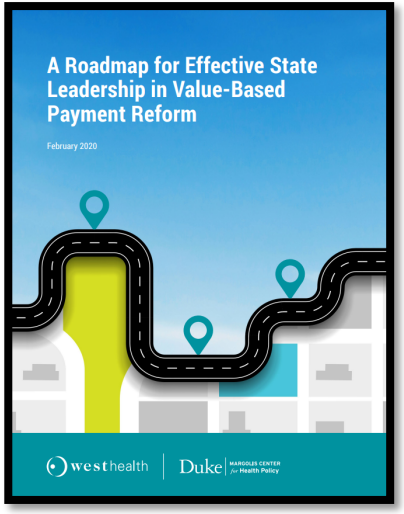
Health Care Payment Learning and Action Network Shared Resiliency Commitments

https://hcp-lan.org/resiliency-collaborative/shared-commitment/

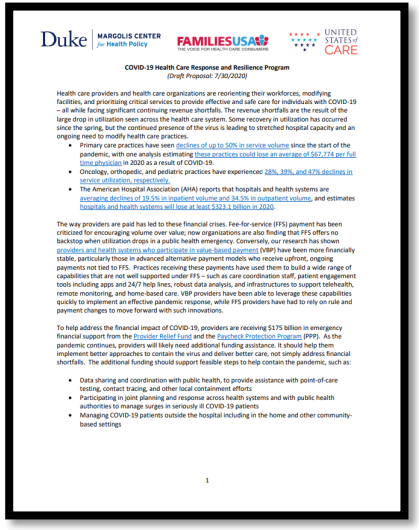
Duke-Margolis Resources on Value-Based Payment and COVID Resiliency



[A Roadmap to Accelerate National Value-Based Payment Reform: Filling in the Missing Pieces*]



[A Roadmap for Effective State Leadership in Value-Based Payment Reform*]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COVID-19 Health Care Response and Resilience Program
(Draft Proposal: 7/30/2020)

Health care providers and health care organizations are reorienting their workforces, modifying facilities, and prioritizing critical services to provide effective and safe care for individuals with COVID-19 – all while facing significant continuing revenue shortfalls. The revenue shortfalls are the result of the large drop in utilization seen across the health care system. Some recovery in utilization has occurred since the spring, but the continued presence of the virus is leading to stretched hospital capacity and an ongoing need to modify health care practices.

- Primary care practices have seen declines of up to 50% in service volume since the start of the pandemic, with one analysis estimating these practices could lose an average of $67,774 per full time physician in 2020 as a result of COVID-19.
- Oncology, orthopedic, and pediatric practices have experienced 28%, 39%, and 47% declines in service utilization, respectively.
- The American Hospital Association (AHA) reports that hospitals and health systems are averaging declines of 19.5% in inpatient volume and 34.5% in outpatient volume, and estimates hospitals and health systems will lose at least $323.1 billion in 2020.

The way providers are paid has led to these financial crises. Fee-for-service (FFS) payment has been criticized for encouraging volume over value; now organizations are also finding that FFS offers no backstop when utilization drops in a public health emergency. Conversely, our research has shown providers and health systems who participate in value-based payment (VBP) have been more financially stable, particularly those in advanced alternative payment models who receive upfront, ongoing payments not tied to FFS. Practices receiving these payments have used them to build a wide range of capabilities that are not well supported under FFS – such as care coordination staff, patient engagement tools including apps and 24/7 help lines, robust data analysis, and infrastructures to support telehealth, remote monitoring, and home-based care. VBP providers have been able to leverage these capabilities quickly to implement an effective pandemic response, while FFS providers have had to rely on rule and payment changes to move forward with such innovations.

To help address the financial impact of COVID-19, providers are receiving $175 billion in emergency financial support from the Provider Relief Fund and the Paycheck Protection Program (PPP). As the pandemic continues, providers will likely need additional funding assistance. It should help them implement better approaches to contain the virus and deliver better care, not simply address financial shortfalls. The additional funding should support feasible steps to help contain the pandemic, such as:

- Data sharing and coordination with public health, to provide assistance with point-of-care testing, contact tracing, and other local containment efforts
- Participating in joint planning and response across health systems and with public health authorities to manage surges in seriously ill COVID-19 patients
- Managing COVID-19 patients outside the hospital including in the home and other community-based settings

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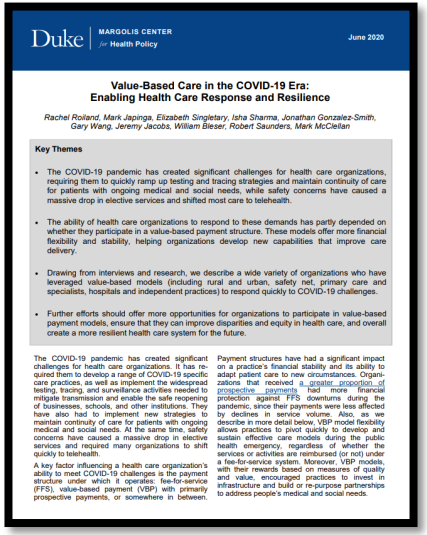
[COVID-19 Health Care Response and Resilience Program]


Duke | MARGOLIS CENTER for Health Policy June 2020

Value-Based Care in the COVID-19 Era:
Enabling Health Care Response and Resilience

Rachel Roiland, Mark Japinga, Elizabeth Singletary, Isha Sharma, Jonathan Gonzalez-Smith, Gary Wang, Jeremy Jacobs, William Bieser, Robert Saunders, Mark McClellan

Key Themes

- The COVID-19 pandemic has created significant challenges for health care organizations, requiring them to quickly ramp up testing and tracing strategies and maintain continuity of care for patients with ongoing medical and social needs, while safety concerns have caused a massive drop in elective services and shifted most care to telehealth.
- The ability of health care organizations to respond to these demands has partly depended on whether they participate in a value-based payment structure. These models offer more financial flexibility and stability, helping organizations develop new capabilities that improve care delivery.
- Drawing from interviews and research, we describe a wide variety of organizations who have leveraged value-based models (including rural and urban, safety net, primary care and specialists, hospitals and independent practices) to respond quickly to COVID-19 challenges.
- Further efforts should offer more opportunities for organizations to participate in value-based payment models, ensure that they can improve disparities and equity in health care, and overall create a more resilient health care system for the future.

The COVID-19 pandemic has created significant challenges for health care organizations. It has required them to develop a range of COVID-19 specific care practices, as well as implement the widespread testing, tracing, and surveillance activities needed to mitigate transmission and enable the safe reopening of businesses, schools, and other institutions. They have also had to implement new strategies to maintain continuity of care for patients with ongoing medical and social needs. At the same time, safety concerns have caused a massive drop in elective services and required many organizations to shift quickly to telehealth.

A key factor influencing a health care organization's ability to meet COVID-19 challenges is the payment structure under which it operates: fee-for-service (FFS), value-based payment (VBP) with primarily prospective payments, or somewhere in between.

Payment structures have had a significant impact on a practice's financial stability and its ability to adapt patient care to new circumstances. Organizations that received a greater proportion of prospective payments had more financial protection against FFS downturns during the pandemic, since their payments were less affected by declines in service volume. Also, as we describe in more detail below, VBP model flexibility allows practices to pivot quickly to develop and sustain effective care models during the public health emergency, regardless of whether the services or activities are reimbursed (or not) under a fee-for-service system. Moreover, VBP models, with their rewards based on measures of quality and value, encouraged practices to invest in infrastructure and build or re-purpose partnerships to address people's medical and social needs.

[Value-Based Care in the COVID-19 Era: Enabling Health Care Response and Resilience]

**Part of a Duke-Margolis partnership with West Health to accelerate value-based payment*

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Thank You!

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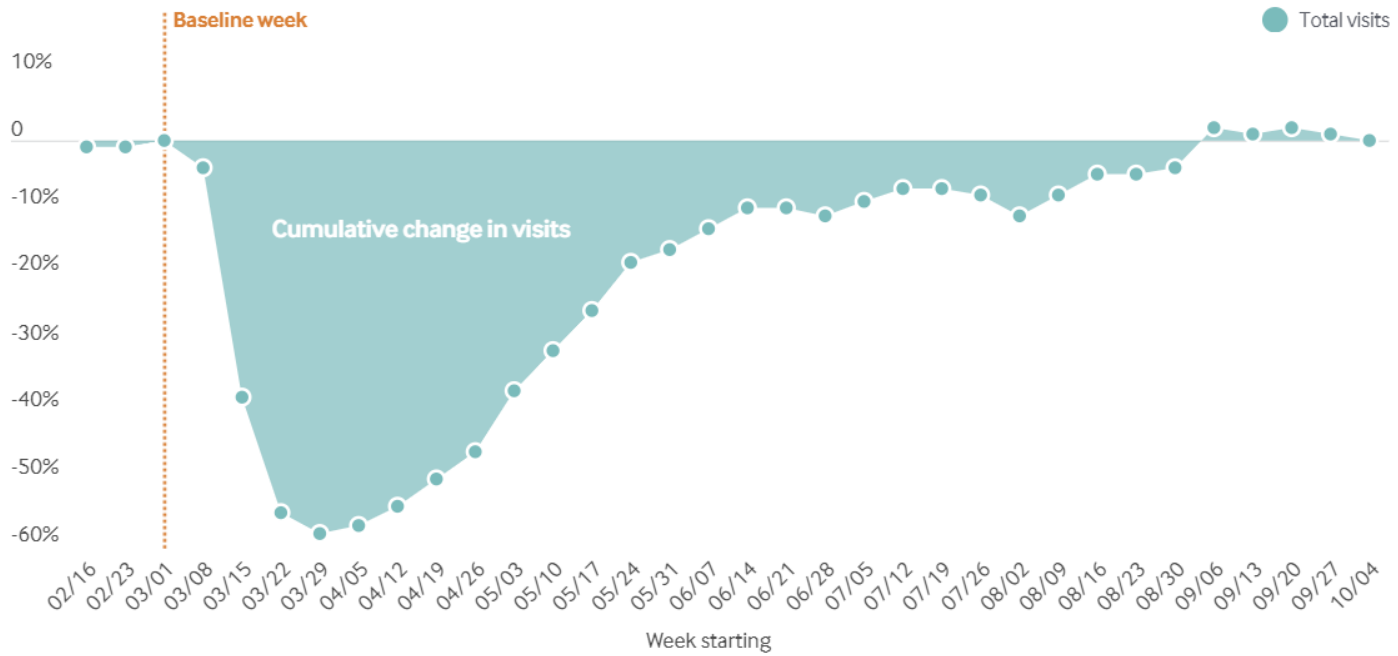
Dr. Ateev Mehrotra Presentation

Telemedicine in the Era of COVID-19

Ateev Mehrotra, M.D.

HARVARD MEDICAL SCHOOL | Department of Health Care Policy

Volume of visits of any types in outpatient care fell by almost 60% before rebounding

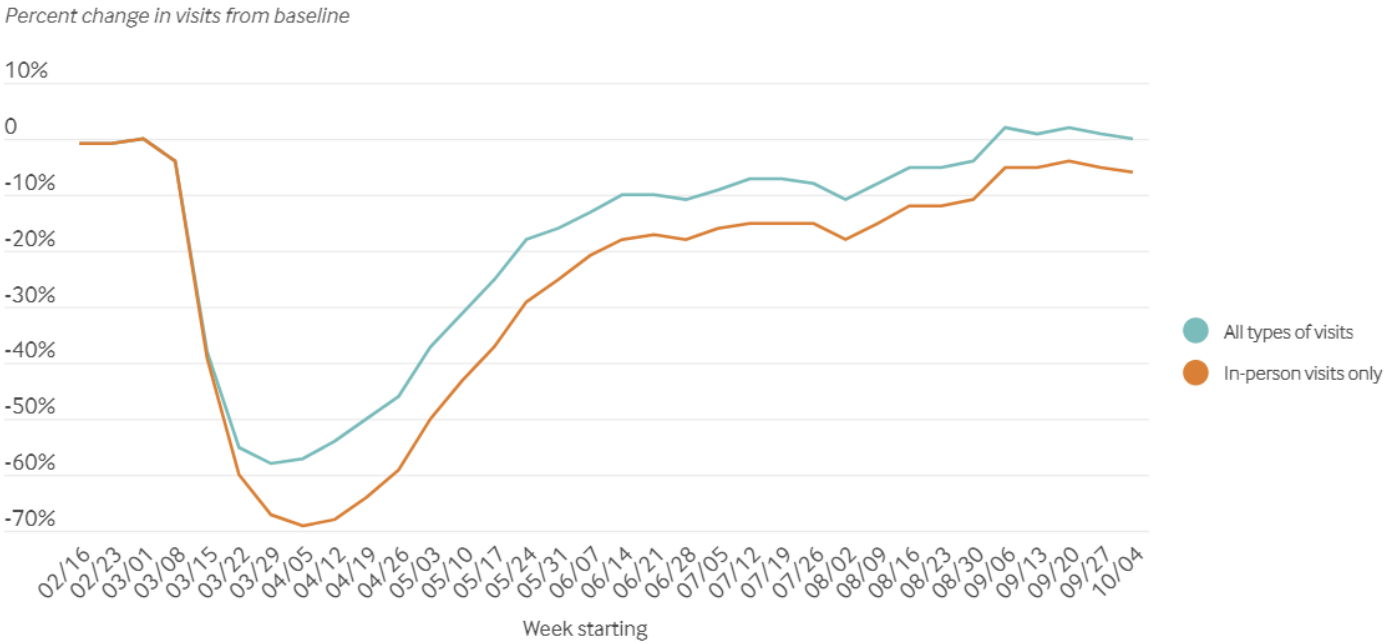


The Impact of the COVID-19 Pandemic on Outpatient Care: Visits Return to Prepandemic Levels, but Not for All Providers and Patients
(Commonwealth Fund, Oct. 2020). https://doi.org/10.26099/41xy-9m57

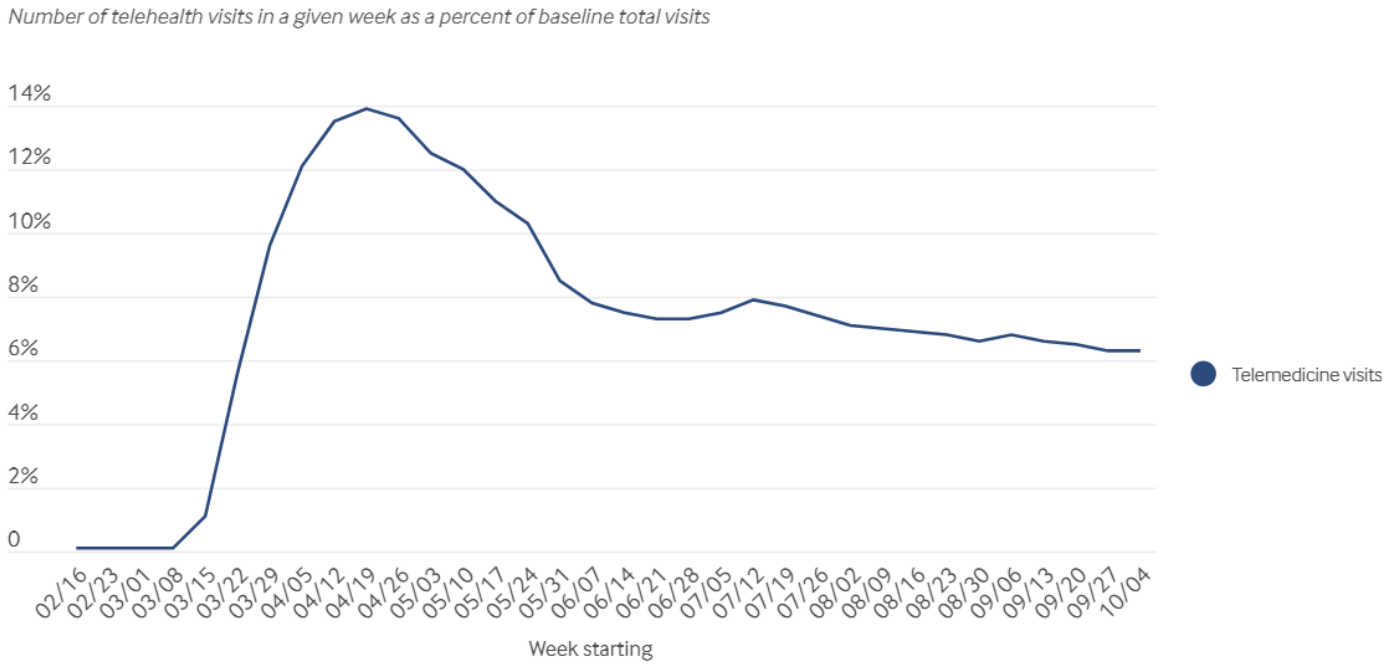
Policymakers implemented many, many temporary changes to facilitate telemedicine use

- Telemedicine visits can be provided to patients in their homes
- All out-of-pocket costs are waived for telemedicine visits
- Payment is mandated for audio-only telephone communications
- Visits are no longer limited to rural residents
- Licensure requirements waived
- Providers prescribe for opioid use disorder using telemedicine
- Types of providers that can deliver a telemedicine visit expanded

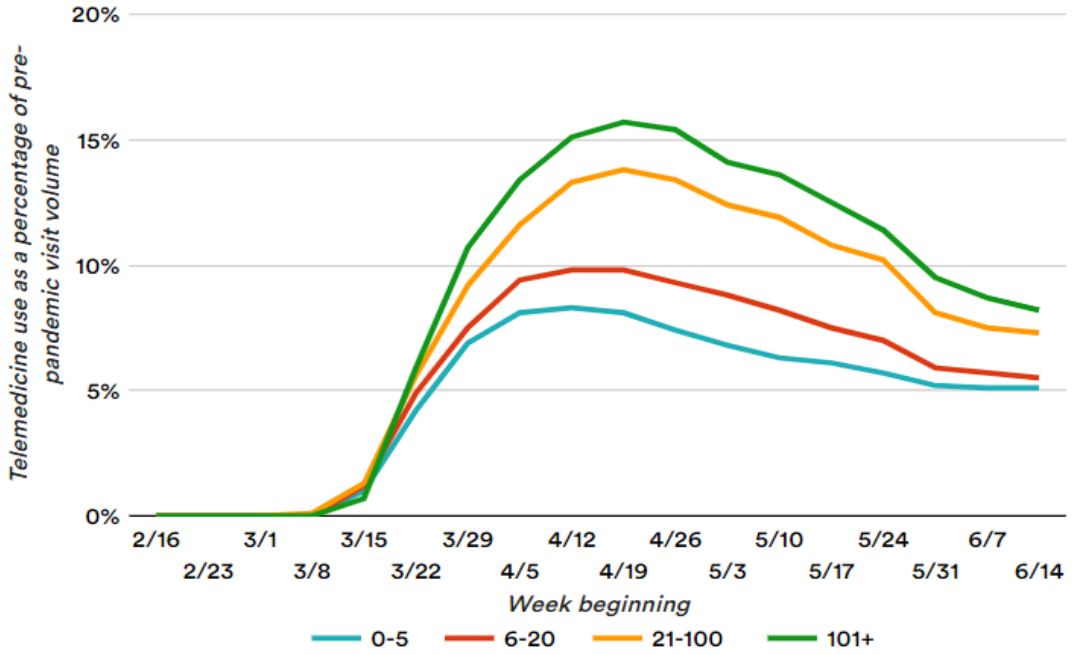
While telemedicine plays a key role in maintaining access, rebound driven by in-person visits



Dramatic rise in use of telemedicine and then a slow decline

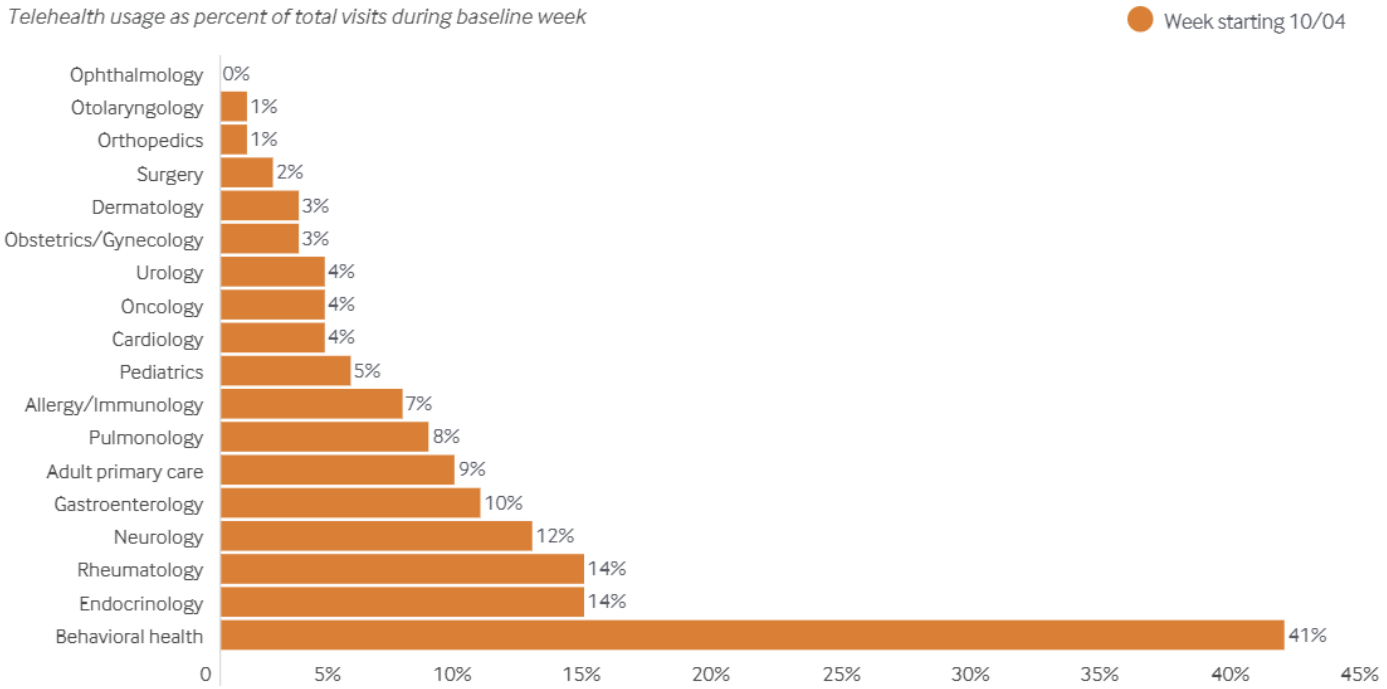


Telemedicine uptake greatest among larger organizations

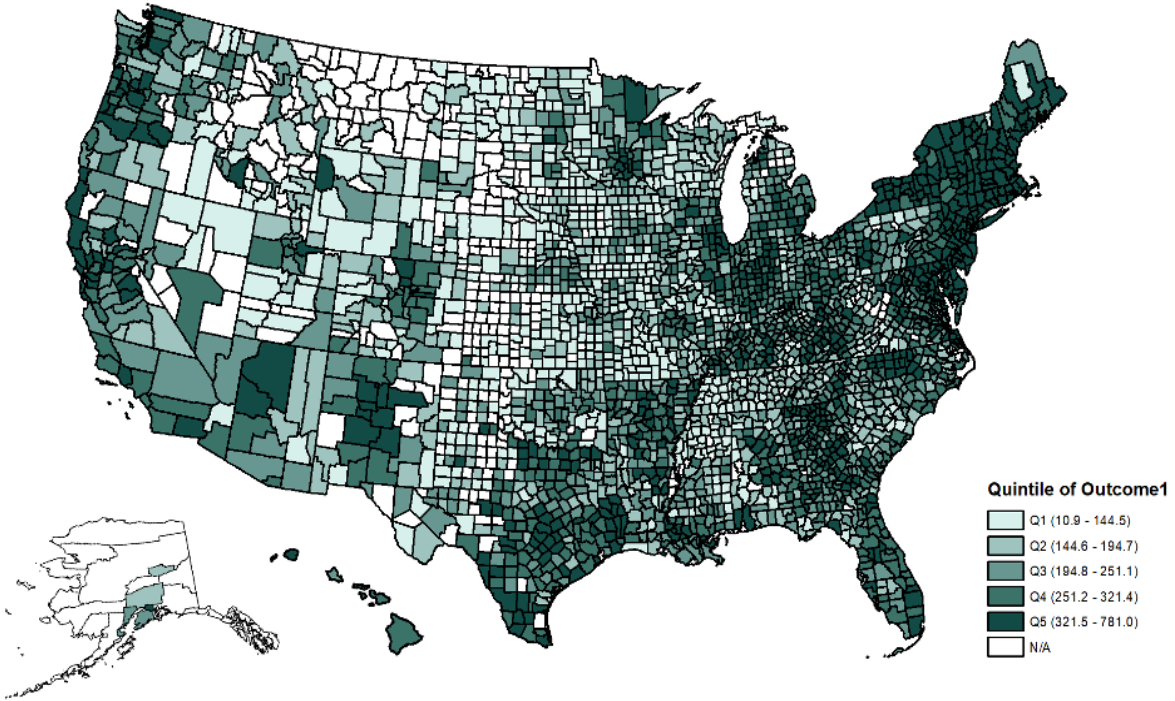


https://www.statnews.com/2020/06/25/telemedicine-time-to-shine-doctors-abandoning-it/

Variation in telehealth use by specialty



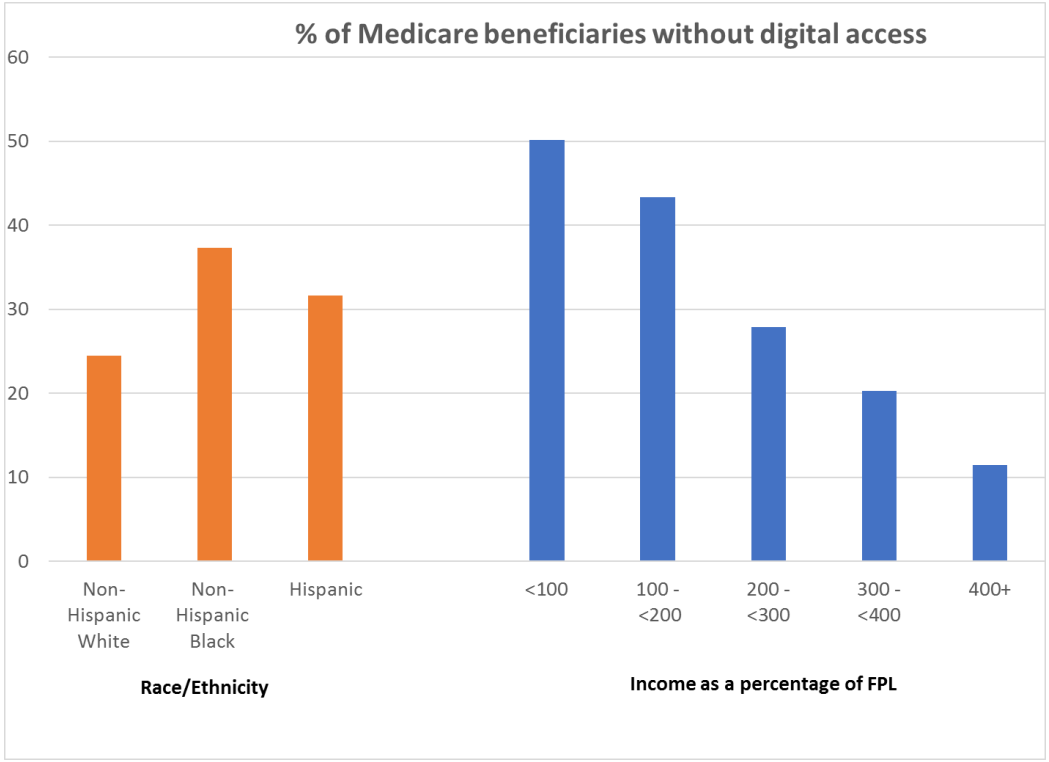
Substantial Geographic Variation



*white indicates counties with less than 100 Enrollees

Preliminary results, please do not cite or distribute

Concern that ‘digital divide’ will limit uptake of telemedicine among disadvantaged populations



Assessment of Disparities in Digital Access Among Medicare Beneficiaries and Implications for Telemedicine. *JAMA Internal Medicine*. 2020

ISSUE BRIEF
August 2020

Telemedicine: What Should the Post-Pandemic Regulatory and Payment Landscape Look Like?

Ateev Mehrotra
Associate Professor of Health Care Policy and Medicine
Harvard Medical School

Bill Wang
Research Assistant
Department of Health Care Policy
Harvard Medical School

Gregory Snyder
Senior Medical Director of Strategy and Clinical Operations
Medically Home

ABSTRACT

ISSUE: In response to the COVID-19 pandemic, many temporary policies were introduced to encourage telemedicine use. There is ongoing debate on what policies should be made permanent.

GOAL: To provide both a framework for how to evaluate telemedicine policies and recommendations on future telemedicine guidelines.

FINDINGS: To encourage higher-value use of telemedicine and discourage overuse of care, we recommend that payments should be limited to services for selected patient populations and health conditions, or to

TOPLINES

- Insurers and policymakers face a difficult challenge in designing an optimal payment and regulatory policy for telemedicine.
- Policies should promote high-value applications of telemedicine but guard against significant overuse.

Challenges

- Sense of urgency given continued uncertainty about long-term plans has deterred investments by providers
- Government and health insurers leery of covering telemedicine visits permanently
- Convenience—key strength of telemedicine—may be viewed as its Achilles' heel
- Concern that in a fee-for-service system there will be "overuse" of telemedicine

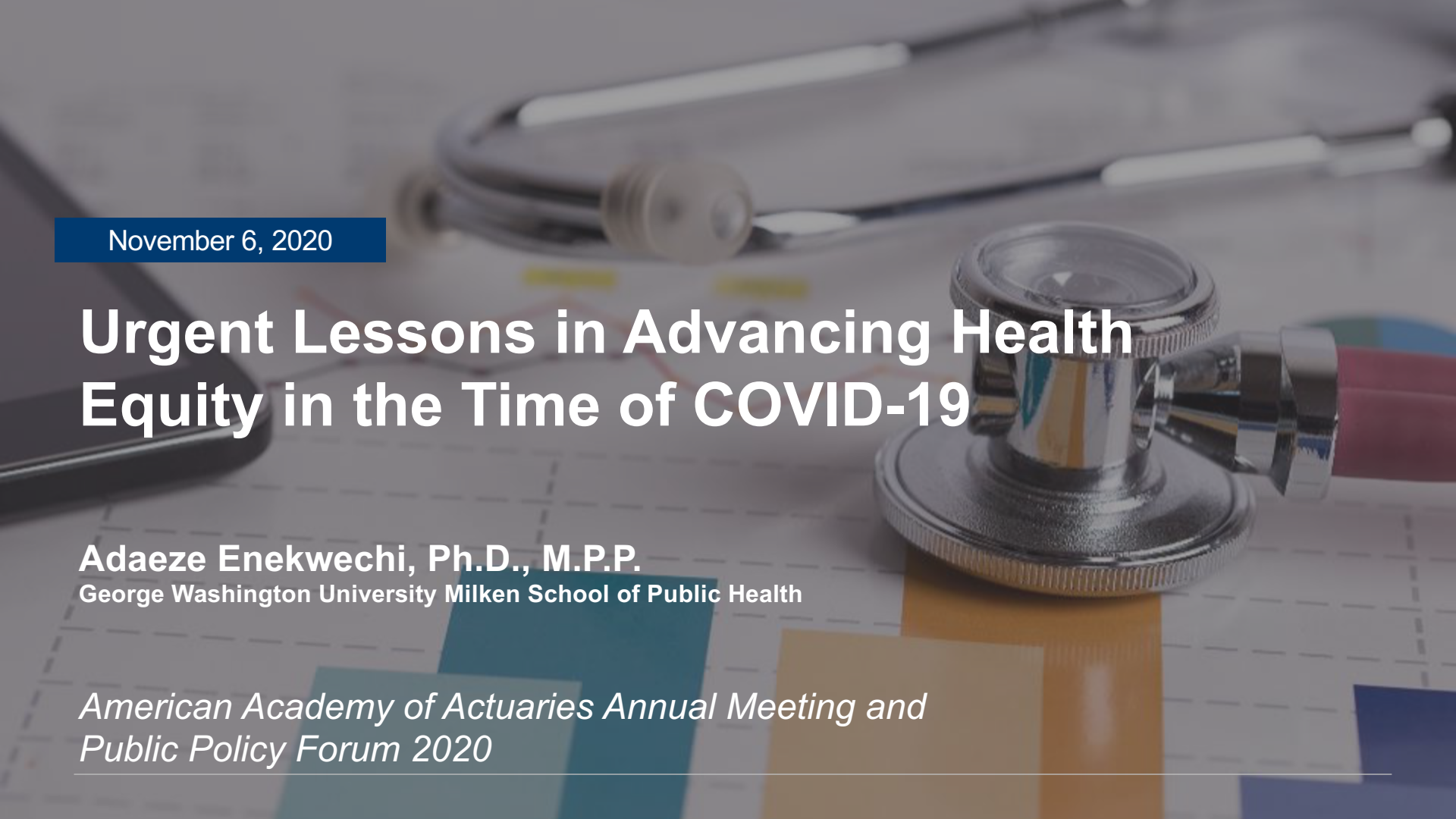
My recommendations

- Telemedicine ≠ video/audio visits
- Should be no single telemedicine policy
- Different policies when providers at risk
- Need for simplicity
- Many tools to address “overuse”
  - Limitations by patient, condition, provider
- Against payment parity
- Only temporary coverage of audio-only visits

Dr. A. Mark Fendrick Presentation

Please access slides at: https://vbidcenter.org/aaa-forum/

Dr. Adaeze Enekwechi Presentation



November 6, 2020

Urgent Lessons in Advancing Health Equity in the Time of COVID-19

Adaeze Enekwechi, Ph.D., M.P.P.
George Washington University Milken School of Public Health

American Academy of Actuaries Annual Meeting and Public Policy Forum 2020

Objectives

- Define health equity.
- Define social determinants of health.
- Requirements to meaningfully advance health equity.
- Understand policy levers that can be deployed now and in the near future to address health equity.

What is
Health Equity?

Health equity is achieved when everyone has a fair opportunity to attain their full health potential and no one is disadvantaged from achieving this potential.

Why Health Equity Matters

- In the U.S., health disparities are vast, persistent, and increasing.
- Many of these gaps are caused by structural racism, poverty, and inequities at all levels and in all areas of society.
- Equity remains a distant reality for many because of the pervasiveness of these barriers.
- It is hard to be healthy without access to proper health care, good jobs and income, quality schools, and safe, affordable homes.

What are

Social Determinants of Health?

Fundamental Cause Theory

*Socioeconomic status and social supports are likely **"fundamental causes" of disease** that, because they **embody access to important resources, affect multiple disease outcomes through multiple mechanisms**, and consequently maintain an association with disease even when intervening mechanisms change.*

Phelan, BG & Link, J. Social conditions as fundamental causes of disease. *Journal of Health and Social Behavior*, 1995

Some Fundamental Causes of Poor Health

- Increased stress
- Weak social supports
- Loneliness
- Discrimination, racism, & bias, which can lead to widespread poverty and low income (housing, transportation, safety, etc.)
- Poor nutrition
- Low health literacy
- Poor health habits (smoking, self-medication)

Hallmarks of Fundamental Causes of Health

Until issues of poverty, structural racism, and bias are addressed, disparities will remain.

- Health disparities are pervasive and are amplified by destabilizing events
- Examples of destabilizing events: Hurricane Katrina, COVID-19 pandemic
- Public health crises exacerbate and magnify existing gaps in society

Advancing Health Equity Requires

- Less patience with admiring the problem
- Recognition that health care alone cannot counteract powerful impact of societal factors
- The will to address SDoH and health equity in our policy, provider, and payer settings
- A focus on equity as our path to a more responsive health care system
- Upfront investments, redirecting resources to targeted populations and needs
- A mission that includes what is best for people in addition to profits

Actuaries can help with health equity focus: Interrogate long-held assumptions

Data	Do data reflect reality of structural barriers on the ground? E.g., Low use may not mean less need for services if few physicians, low access in poor/disenfranchised communities of color. Check assumptions of straight analytics?
Incentives	What incentives are embedded in the system for providers? Adequate networks? For payers? When we are paying for value, who defines value?
Drivers of Health	Where are people/patients starting from in their health? Food insecurity, poor education, unstable home, poor income? How are health systems working to address these fundamental causes of health?
Provider Reimbursement	Do differences in provider payments exacerbate inequities? Are value-based payment models robust enough to address service gaps for the most vulnerable people?
New Technology	How user-friendly is it? How does it serve people without broadband? Demographic characteristics of current users?

The Business and Economic Case for Tackling Health Inequity is Strong

US$82B

Estimated total cost of racial/ethnic disparities in 2009—US$60B in excess health care costs and US$22B in lost productivity

US$353B

Projected economic burden of health disparities in the U.S. in 2050 if they remain unchanged

Source: Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. Achieving Health Equity: A Guide for Health Care Organizations. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016. (Available at ihi.org)

Moving Forward on **Health Equity**

Challenges	Opportunities
We don't have the data systems to deal with these issues.	We do. We have location, transportation, race/sex/age, and household data. **We need to ask the right questions** to integrate and use data.
Where do we begin?	**Your executive leadership**. Chief Health Equity Officers with resources, data, and ability to initiate change. Moral compass.
How can clinicians be expected to deal with social factors?	We can hire case/care managers and **partner up** with other non-clinical providers. Problems will not be solved by health care providers but could be the **hub**.
What is the business case for a hospital or physician practice group?	The **business case is proven in the math**, if we prevent a readmission, hospitalization, or institutional PAC use. We need to **admit that business cases are not universal**.
There are no tools with which to address social factors.	Compassion. Understanding. Trained staff. Educated population and clinicians. Targeted resources. Patience. **Perhaps we start with one or two manageable problems**.
We don't have any experience partnering with community-based organizations.	We might need to tweak our process, **share information**, and equip them with additional tools to do what they do best.
We don't know what people need.	**Ask them**. Use valid instruments and keep them dynamic.

Levers to Address Large-Scale Change

Focus	Data	Funding	Diverse Leadership	Bias Training	Time
Buy-in by corporate, federal, and state leaders that it is in our collective best interest in to address major inequities • It costs us all and the country suffers from unrealized potential	Integrated data needs to bring together health, social, economic, and geographic data	A commitment from lawmakers and policymakers to begin efforts to jointly fund health, education, transportation, housing, and food initiatives at community level	Diverse senior leadership teams with the will and ability to galvanize efforts and resources	Training is needed for medical staff about unequal treatment, structural racism and effects, and implicit bias	Meaningful runway is needed to effect measurable change and improvements (we did not get here overnight, so we won't solve anything overnight)

Disclosures

- Public Health Institute
- Alliance for Health Policy
- BehaVR
- Dovel Technologies
- *All opinions are my own*

Thank You

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Q&A