**Appendix – Payment Reorientation**

**Telehealth Network**

1. Startup dollars potentially a mix of initial grant funding and/or monies from converting existing facility based capacity
2. Ongoing monies – fixed charge per telehealth encounter
3. RCE Management – fixed administrative fee per service plus block network amount for infrastructure
4. RCE management adjusted for system quality – users (providers and patients) provide feedback on quality of services
5. RCE management fixed fee adjusted for reimbursable service volume growth

**Example Implementation.**

In Year 1 the service is initiated within the region with a fixed start up budget of $2,000,000.

The RCE administrators track utilization and for every telehealth encounter charge a fixed fee. This amount will be dependent upon transaction volume. If the volume of transactions is below projection then monies will have to be subsidized from reserves allocated from the start up budget. If volumes are sufficiently high then reserves will be capitalized. Significant variation will result in transaction fee reduction in future years.

In Year 2 the RCE management may be entitled to a performance bonus. This would result from quality evaluation of network performance and the ability to grow transaction volume (which keeps individual transaction fees down). Alternatively performance failure may be met with removal of the RCE administration team.

**Health management: For services directly managed by the RCE**

1. Payment rates are set by contract for services (FFS component) – for historically underserved communities FFS is important if access is to be expanded
2. FFS component is adjusted for population health outcomes. Some percentage of payment is tied to a quality component.
3. Quality dollars are tied to two outcomes domains:
4. Monetary – readmission rates, facility utilization, health status change – these are rates that can be computed to have a dollar impact
5. Non-monetary – RCE wide population mortality rates, patient engagement/empowerment – these are tangible benefits that should be incorporated into the payment adjustment. Lower mortality will likely increase costs while increased patient engagement/empowerment will likely decrease costs.
6. Monies recovered under i) should be used to finance gains measured under i) and ii) so as to not add additional cost burden.
7. Calculating RCE outcomes rates provides cross comparison of the relative effectiveness of RCEs and RCE management.
8. Track and incentivize the volume of services delivered via telehealth – ultimately this will be a major source of sustainability.
9. After an initial building period it should be possible to switch the historical FFS model to a capitated model.

**Example Implementation.**

In Year 1 the RCE attains control of billing and administrative reporting for physicians covered by the management group. In return for permitting the consolidation of services and, potentially, an enhanced payment rate under FFS the RCE is set a series of quality gates based upon community and population health.

In Year 2 performance under the quality gates are assessed. Results under the quality gates would drive FFS rates for the upcoming year (prospective). In keeping with the standalone telehealth hub model the RCE would look to reserve an administrative fee to develop community health infrastructure.

In Years 4 or 5 the RCE would begin offering payers a capitated alternative to population health management. The time delay results from the need to build a necessary structure of telehealth and supportive services to the community.