VIRGINIA TASK FORCE ON PRIMARY CARE

Years 1 & 2
SUMMARY REPORT

Years 3 & 4
WORKPLAN AND CURRENT ACTIVITIES

For John E. Littel
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BACKGROUND: TASK FORCE AIMS AND DEFINITION OF SUCCESS

In August 2020, the Virginia Center for Health Innovation (VCHI) launched the Virginia Task Force on Primary Care, which aims to:

- Build a stakeholder coalition to direct primary care support and advance the use of data/communication systems for action;
- Define payment models to better support primary care and support practice viability through systems that allow for predictability in financial support;
- Describe the infrastructure needed to support primary care;
- Identify markers of high value care in the COVID and post COVID era to function as quality metrics; and
- Promote innovations in telehealth, population health management, and outreach to adapt to the changing COVID environment.

The 31 task force members, comprised of primary care clinicians, employers, health plan representatives, patient advocates, and state government leaders from the executive and legislative branches defined success as:

- Clinicians and payers establish a better relationship in order to partner in seeking better health and lower costs for Virginians;
- Primary care services are accessible, integrated, equitable, convenient, and affordable for patients in all Virginia communities;
- Virginia promotes a positive primary care practice experience for clinicians, leading to retention and growth in the number of primary care providers;
- The viability of primary care practices is safeguarded, primary care payment is predictable and tied to meaningful performance measurement in order to advance better health care value, and primary care is less susceptible to changes in the economy; and
- Positive primary care innovations, such as telehealth, adopted during the pandemic are maintained and advanced where needed.

The task force was funded in Year 1 with a $204,610 grant from Arnold Ventures and the support and engagement of Governor Ralph Northam and Virginia Secretary of Health and Human Resources, Daniel Carey, MD. The task force was then funded in year two through a $297,295 contract with the Virginia Department of Medical Assistance Services.

SUMMARY OF YEAR 1 IMPACT AND RECOMMENDATIONS

IMPACT

PANDEMIC SUPPORT

- One-time distribution of 750,000 pieces of PPE and 500,000 rapid antigen tests to Virginia's primary care clinicians, free clinics, and FQHCs
- Dissemination of educational information on PPE utilization strategies and a recommended PPE vendor list to all Virginia primary care clinicians

CONNECTING VIRGINIA WITH NATIONAL PRIMARY CARE REFORM ENTITIES

- Through the VTFPC and VCHI, the Commonwealth of Virginia has been invited to participate in AHRQ's Primary Care Learning Community and Milbank Memorial Fund's Multi-Payer Primary Care Network, both of which offer considerable resources for reform work

IDENTIFICATION OF NECESSARY BUILDING BLOCKS FOR PAYMENT REFORM

- Partnership with key entities to begin development of Primary Care Spend Report and a Total Cost of Care Report
- Partnership with key entities to learn more about the infrastructure needs of primary care clinicians to participate in Value-Based Payment (VBP) contracts
- Partnership with Virginia Medicaid to begin the development of a primary care payment reform model
- Development of a series of performance measurement aims and key stakeholder requirements that will be utilized to drive improved measurement effectiveness and alignment for all parties
- Recognition of communication and data sharing challenges in the necessary relationship between primary care and public health and a commitment to improving connectivity

RECOMMENDATIONS

1. Virginia's health plans voluntarily implement one or more of the following options for their commercially fully-insured and willing self-insured customers:

    A. Extend the telehealth provisions of HB 5046 and the identical SB 5080; and/or

    B. Reimburse CPT 99072 at a rate not below $6.57 for the later of the duration of the Public Health Emergency or December 31, 2021; and/or

    C. Pay each PCP $2 PMPM for patients attributed to them by curren methodologies, starting as soon as feasible and for one year or the duration of the Public Health Emergency, whichever is longer, IF the PCP agrees to a contract wherein, within one year of the end of the Public Health Emergency, the PMPM amount or other non-FFS payment will depend upon performance on quality, patient experience, and total cost of care metrics; and/or

    D. Implement an enhanced FFS payment plan that would apply to all PCPs and pay all FFS evaluation and management CPT codes at 110% of current rates, starting as soon as possible and continuing for one year or the duration of the Public Health Emergency, whichever is longer.

2. Virginia's health plans, with assistance from the Virginia Association of Heal Plans, submit a report to the Virginia Task Force on Primary Care no later than February 1, 2021 detailing the specific financial support each provided to Virginia primary care clinicians to address pandemic issues from March 1, 2020 through December 31, 2020. This data will be utilized to better inform long-term task-force recommendations. This report should include, but is not limited to, data pertaining to increases in FFS rates, PMPM, PPE CPT code reimbursement, and expansions in telehealth coverage.

3. Virginia Medicaid submit a report to the Virginia Task Force on Primary Care no later than March 1, 2021 detailing the anticipated impacts (financial, logistical, access) of:

    A. Paying for Medicaid primary care services at parity with Medicare and

    B. of implementing a PMPM model for Virginia Medicaid.

Copies of the required presentations by the Virginia Association of Health Plans and Virginia Medicaid are included as Attachment A and Attachment B.

SUMMARY OF YEAR 2 IMPACT AND RECOMMENDATIONS

IMPACT

ESTABLISHMENT OF BASELINE SPENDING REPORT DATA

- Reviewed potential primary care spend (PC Spend) and total cost of care (TCoC) reporting methodologies from other states and discussed Virginia priorities
- Selected methodologies for both reports and secured necessary data use agreements
- Created a consensus 4-quadrant definition of primary care
- Ran both report analyses, and shared with committee members to gather input and troubleshoot data irregularities
- Prepared baseline key highlights reports for both PC Spend and TCoC
- Agreed to partner with the Robert Graham Center at AAFP to pilot a NASEM-based primary care accountability scorecard

IDENTIFICATION OF NECESSARY INFRASTRUCTURE SUPPORTS FOR PRIMARY CARE

- Developed suggestions for improving communication and data sharing between primary care and public health and shared these with Deloitte as part of its contracted development of a new strategic plan for the Virginia Department of Health (VDH)
- Supported the VHI recommendation that Virginia secure a bidirectional tool (ImmuTrak) for vaccination data sharing. Funding for ImmuTrak has been secured through VDH and the roll out will begin in 2023
- Developed a concept model for enhancing primary care infrastructure supports
- Partnered with Dr. Alex Krist and the VCU Department of Family Medicine and Population Health to expand the impact of the DMAS contracted 2022 Primary Care Practice Survey to include 25 practice interviews

BUILDING CONSENSUS FOR MORE EFFECTIVE PERFORMANCE MEASUREMENT

- Developed grid capturing ideal state of primary care from each stakeholder perspective
- Identified seven essential measurement categories:
    - Person-Focused Primary Care Measure
    - Person-Centric Diversity and Health Equity Measure
    - Person-Centric Health Literacy Measure

- Patient Reported Cost Burden Measure
- Primary Care Clinician Measure
- Accountability Measure between Employers and Health Plans
- Clinical Competency Assessment

- Developed a plan for piloting the Patient-Centered Primary Care Measure and the What Matters Index and identified possible pilot participants

CONTINUED IDENTIFICATION OF NECESSARY BUILDING BLOCKS FOR PAYMENT REFORM

- Prepared a primer on other states' recent efforts to reform Medicaid primary care payment

- Reviewed available data on the composition of Virginia's primary care workforce, with a specific focus on the nature of the associated ownership arrangements and the impact these may have on incentive-based contracts

RECOMMENDATIONS

With this second year of work underway, the Virginia Task Force on Primary Care advanced the following legislative recommendations:

Budget Item: 304 #19h (Coyner) and 304 #5s (Dunnavant)

Explanation: This amendment adds $18.9 million the first year and $45.2 million the second year from the general fund and $20.4 million from the nongeneral fund the first year and $64.3 million from the nongeneral fund the second year from matching federal Medicaid funds and other nongeneral funds to implement a reimbursement increase for primary care providers to 100% of the federal fiscal year 2021 Medicare equivalent and to implement a value-based purchasing program. A value-based payment model provides the flexibility and support providers need to adjust practice patterns and invest in enhancements necessary to focus om population health management, increase members' access to lower-acuity settings, preventive care, complex care management services, and chronic disease management.

Purpose: This money will be used to increase Medicaid payments for primary care providers and services to be in line with Medicare rates. In addition, the funding will be used to implement a value-based purchasing model that will improve patient outcomes, increase provider participation in Medicaid, and help meet the needs of Medicaid patients.

Language: The Department of Medical Assistance Services (DMAS) shall work with the appropriate primary care stakeholders and Medicaid managed care organizations to develop a unified, value-based purchasing (VBP) program for primary care providers (PCP) that includes enhanced funding for PCPs that meet or exceed performance and/or improvement thresholds as developed, reported, and measured by DMAS in cooperation with participating providers. As part of this effort, DMAS shall define the structures for PCP accountability and disbursement of earned financial incentives. For the purposes of the Virginia PCP VBP program, DMAS shall use the definition of primary care providers and services developed by the Governor's Task Force on Primary Care with allowance for any modifications necessary for implementation. PCP performance evaluation under the program shall prioritize avoidance of negative care events, management of chronic conditions, and other relevant domains of care indicative of the quality of care furnished to Medicaid members. Enhanced funding under this program shall be increased to 100 percent of the federal fiscal year 2021 Medicare equivalent as calculated by the department and consistent with the appropriation available for this purpose. This enhanced funding shall only be available to PCPs that actively provide care for Medicaid members and the program structure shall give consideration to any current VBP arrangements in place between Medicaid managed care organizations and PCPs. The Virginia PCP VBP program shall begin no later than January 1, 2024. The department shall implement the necessary regulatory changes and other necessary measures to be consistent with federal approval of any appropriate changes to state plan or relevant waivers thereof, and prior to the completion of any regulatory process undertaken to effect such change."

Budget Item: 308 #1h (Hodges) and 308 #3s (Dunnavant)

Explanation: This amendment provides $508,750 the first year and $816,750 the second year from the general fund for the Department of Medical Assistance Services to contract with the Virginia Center for Health Innovation for actions necessary to facilitate and support the Virginia Task Force on Primary Care in years three and four of the Governor's Task Force on Primary Care. It also changes the name to the Virginia Task Force on Primary Care.

Purpose: The Task Force is working to build Virginia's primary care assessment infrastructure - with deliverables including primary care and total cost of care spend reports, a bidirectional tool to enhance immunization data sharing, a primary care performance dashboard, a plan to enhance primary care infrastructure support and connectivity with public health, and a payment reform model for Medicaid that includes new accountability metrics. Working closely with Virginia Health Information, we are advancing system change by reviewing data and identifying key drivers of data variation.

THE END RESULT, AS APPROVED BY THE VIRGINIA GENERAL ASSEMBLY, AND SIGNED BY GOVERNOR YOUNGKIN:

- Funding the Virginia Primary Task Force in Full ($1.3 M over two years)

- Increasing Medicaid funding for primary care services by $82M over two years, roughly increasing payment from 70% to 80 % of the Medicare rate. No Value-Based Payment requirements were included.

- As part of this approval, VCHI's contract was moved to the Virginia Department of Health, and the following requirement was added:

  The Secretary of Health and Human Resources, in collaboration with appropriate stakeholders, shall continue to support the efforts of the Governor's Task Force on Primary Care. The Secretary shall assist the Task Force to enhance the financing, quality and delivery of primary care in the Commonwealth. The Secretary and task force should continue work on 1) building stakeholder coalitions; 2) advancing the use of data/communication systems; 3) defining payment models; 4) describing primary care infrastructure; 5) identifying markers of high value care; and 6) promoting innovations in telehealth. The Secretary of Health and Human Resources shall report on task force activities to the Governor and Chairmen of the House Appropriations and Senate Finance and Appropriations Committees by December 1, 2022.

THIS REPORT IS DESIGNED TO SATISFY THIS REQUIREMENT. SUBSEQUENT SECTIONS WILL DETAIL EFFORTS TO DATE TO ADDRESS:

A. Stakeholder Coalition Building
B. Advancing Use of Data/Communications Systems
C. Defining Payment Models with an Early Focus on Medicaid
D. Describing Primary Care Infrastructure
E. Identifying Markers of High Value Care
F. Promoting Innovations in Telehealth

A. STAKEHOLDER COALITION BUILDING

The Virginia Task Force on Primary Care is presently comprised of an overarching task force and four committees (Spend Reports and Data Analytics, Performance Measurement, Payment Reform, and Clinician Retention and Well-Being). A fifth committee, the Infrastructure Supports Committee, which operated in FY'21 and FY'22, has been replaced by the launching of a virtual on-line network, the Virginia Primary Care Health Innovation Hub.

The hub offers designated work space and opportunities for connectivity to task force and committee members, while remaining accessible to anyone interested in improving the provision of primary care services in the Commonwealth. (More on the Virginia Primary Care Innovation Hub can be found in Section D below).

For FY'23, the task force consists of 31 members, and the committees include an additional 41 members, for a total of 72 representatives directly engaged in our work. These individuals include representatives of Virginia's executive and legislative branches, all primary care clinician organizations, most health plans and health systems, as well as patient advocates and employer health benefit design leaders. All geographic regions of the Commonwealth are well represented. Each committee is purposely co-chaired by a primary care physician champion and a health plan leader to ensure that when recommendations emerge, they have been thoroughly vetted by the essential parties. This approach led to the formation of a strong coalition in FY' 22 that worked collaboratively to ensure the successful adoption of the task force's legislative agenda.

A complete list of those engaged in the work of the Virginia Task Force on Primary Care can be found at https://www.vahealthinnovation.org/virginia-task-force-on-primary-care/.

B. ADVANCING USE OF DATA/COMMUNICATIONS SYSTEMS

The Spend Reports and Data Analytics Committee was charged with determining what information would be most beneficial to the task force aims of advancing payment reform and the utilization of high value care markers. It identified 2 key areas of focus: a) better understanding the composition and ownership arrangements of the primary care workforce; and b) better understanding primary care spending and its association with total cost of care.

To address area a) – ***better understanding the composition and ownership arrangements of the primary care workforce*** – the task force contracted with researcher Alex Krist, MD, MPH and Virginia Commonwealth University, to support an expansion of a primary care practice survey that was already in development. The results of this work are shared in Attachment C, with an accompanying article published in the Annals of Family Medicine https://www.annfammed.org/content/20/5/446. Additional analysis of the survey is expected in December of 2022 and will be shared at that time.

PRELIMINARY FINDINGS FROM THE PRIMARY CARE PRACTICE SURVEY INCLUDE:

- Among the 20,976 active physicians in Virginia, 5,899 (28.1%) met the survey definition of primary care physicians. Family medicine physicians represented 52.4% of these primary care physicians, internal medicine physicians 18.5%, pediatricians 16.8%, obstetricians and gynecologists 11.8%, and other specialists 0.5%.

- Primary care practice ownership has changed significantly in the past four years. In 2018, 53% of practices were clinician owned and 25% were health system owned. By 2022, those numbers had reversed in magnitude to 39% clinician owned and 43% health system owned. This change in ownership arrangement will impact the ability of VBP incentives to change clinician behavior, depending on who is bearing risk and who is eligible to earn rewards.

- Primary care practices are under considerable stress. More than half (53.2%) of survey respondents reported experiencing at least one major challenge in the past year. These included: losing at least one physician, NP, or PA (42.2%); undergoing an office renovation (8.4%); changing EMR (7.2%); changing billing system (6.4%); changing ownership (5.7%); or moving their office (5.3%). Responses suggest that we are only now beginning to see the impact of this significant burnout.

- There is a wide distribution across primary care practices on percent of Medicaid patients accepted. For this reason, we may want to focus our VBP reform efforts on those practices seeing a certain threshold of Medicaid patients.

- A number of important changes will be needed if most primary care practices are going to accept more Medicaid patients. In addition to better payment, these include better access to the following: mental health providers, specialists, local community health workers, local social workers, and local nutritionists.

- There is interest by Virginia's primary care practices in participating in VBP models, but the impact of VBP on most practices has been fairly limited to date.

To address area b) – understanding primary care spending and its association with total cost of care – the task force contracted with Virginia Health Information and Milliman MedInsight to produce a Virginia Primary Care Spend Report and a Virginia Total Cost of Care Report. Slides depicting a summary of this work is included in Attachment D. Highlights from both reports are provided below.

PRIMARY CARE SPEND REPORT HIGHLIGHTS

This data analysis provides some evidence that the Virginia Primary Care Task Force was correct in expressing deep concern about the viability of primary care in our Commonwealth. Looking at primary care spend using a range of definitions, we can see that in ALL scenarios, across all three years reviewed, primary care appears to be significantly under-resourced as a percentage of total cost of care compared with national and international recommendations.

Research consistently demonstrates that where primary care is well resourced, health outcomes are better and the workforce is more productive. [1]But where primary care is thin, the community suffers.

- The U.S. has historically spent less than most developed countries on primary care in proportion to other services – between 5 and 7 percent[2] – and arguably experiences higher overall costs and worse health outcomes as a result. By comparison peer OECD countries average 14 percent spending on primary care.[3]

- Using 2019 as our most current reliable year of data (given 2020 COVID impacts) and looking across all four quadrants of primary care provider and service definitions (narrow/narrow to broad/broad) - we see that primary care spend as a percentage of total cost of care is lowest in Medicaid (1.0- 3.3% depending on year and definition) and highest for the commercially insured (3.3- 7.2% depending on year and definition).

- When we look at actual primary care spending for 2019, per member per month, with and without risk adjustment, we also observe differences across insurance types.

	Primary Care Spend PMPM	Risk-Adjusted Primary Care Spend PMPM
Commercial	$21.49	$22.98
Medicaid	$17.31	$8.57
Medicare	$43.17	$36.50
All Payers	$29.24	$21.69

- Looking at the regional analysis, we see primary care spend as a percentage of total cost of care is lowest in the central region's Medicaid population (1.1%) and highest in the central region's commercial population (6.6%).

- Even before the pandemic, Medicaid spend on primary care services as a percentage of total cost of care appeared to be headed in the wrong direction. Using the narrow set of definitions, it went from 2.0% in 2018 to 1.3% in 2019 to 1.0% in 2020. Using the broad set of definitions, it went from 3.3% in 2018 to 2.2% in 2019 to 1.8% in 2020.

- Virginia's eastern region consistently demonstrates the lowest primary care spend as a percentage of total cost of care when looking at ALL payer averages from 2018-2020 (1.8- 3.7%).

- Urgent care services still represent a relatively small percentage of Virginia's primary care medical spend, ranging from 1% (Southwest region Medicare 2019) - 11% (North west region Medicaid 2019).

- Virtual care appears to have increased significantly as a percentage of primary care medical spend in 2020 (from .11% in 2018 to 8.04% in 2020 using the broad/broad definition and from .04% in 2018 to 10.44% in 2020 using the narrow/narrow definition). This will be interesting to continue to track.

[1] Baillieu R, Kidd M, Phillips R, et al. The Primary Care Spend Model: a systems approach to measuring investment in primary care. BMJ Glob Health. 2019;4(4):e001601. Published 2019 Jul 10. doi:10.1136/bmjgh-2019-001601

[2] https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2765245

[3] https://www.oecd.org/health/health-systems/Spending-on-Primary-Care-Policy-Brief-December-2018.pdf

- The age of the population utilizing virtual care also appears to be increasing, from a mean age of 40 in 2018 to 51 in 2020 (using the narrow/narrow definitions).

- Even when employing our broadest set of primary care provider definitions, we see that a considerable portion (44.92% in 2019) of primary care services are being delivered by specialty medical providers. This is referred to as primary care leakage in the report, which typically results in higher total cost of care.

- We can also use this data analysis to review how Virginia is allocating its primary care spend. Using our broadest definition of primary care providers and services, we see:

    - The percentage of primary care spend dedicated to preventive, well care, and acute visits for "healthy" individuals varies significantly by type of insurance, partially attributable to the mean age of the patients covered. This ranges from 14.6% of primary care spend for Medicare (mean age 69), to 36.4% for Medicaid (mean age 24), to 41.8% for commercial (mean age 36).

    - Spending on mental health services represents an increasing percentage of primary care spend for public health insurers. From 2018- 2019, spending for depression, substance abuse, major psychosis, severe dementia, and other mental health services increased from 11.7% - 13% of total primary care spend for Medicare, and from 7% - 10.2% for Medicaid. This is in contrast to trends in the commercial market, where primary care spending for these services decreased from 6.2%- 5.4% of total primary care spend.

    - The allocation of primary care dollars to defined health groupers appears to differ significantly by type of insurer. For example, looking at the top five grouper categories by percentage of primary care spend we see:

Commercial	**Medicare**	**Medicaid**
Hypertension (9.2%)	Hypertension (14.9%)	Mental Health (10.2%)
Diabetes (5.7%)	Mental Health (13%)	Intellectual Disability (9.2%)
Mental Health (5.4%)	Diabetes (10.3%)	Asthma (8.2%)
Asthma (4.5%)	Cancer (9.6%)	Unhealthy Newborns (5.2%)
Cancer (3.9%)	Renal Failure (9.5%)	Hypertension (5.2%)

TOTAL COST OF CARE REPORT HIGHLIGHTS

- This data analysis provides a deep dive into the cost and cost drivers of health care in Virginia. Specifically, it looks at the cost drivers of major services and of chronic conditions, and segregates the analysis by insurance type (Commercial, Medicare FFS and Medicare Advantage, and Medicaid) and by health planning region (Central, Eastern, Northern, Northwest, Southwest). The data has also been risk-adjusted for 2019 and 2020.

- While trend information from this methodology will be very informative in future years, it should be qualified in this first report, as two major events impact the data. In 2019, Virginia significantly expanded its Medicaid enrollment. In 2020, the Covid-19 pandemic impacted health care utilization and methods of service delivery for all patients and providers.

- Two other significant notes: First, while the data in this report has been risk-adjusted for 2019 and 2020 using the Milliman MedInsight's MARA methodology, it was not possible to conduct the same risk-adjustment for 2018, as MARA scores were not available then. Second, the Medicare FFS cost data does not include pharmaceutical costs, as CMS does not include that data with its submissions to VHI. Pharmaceutical cost data is included for the Commercial, Medicaid, and Medicare Advantage analyses.

- Not surprisingly, per member per month costs are on the rise in almost every scenario examined – with one exception. As noted in the chart below, non-risk-adjusted Medicare FFS claims actually decreased from 2018-2020. Recall, however, that the Medicare numbers do not include pharmaceutical costs, while the others do.

ALLOWED PMPM FOR ALL COMBINED REGIONS OF VIRGINIA

Year	Com-merical	Com-mercial RA	Medi-care FFS	Medi-care FFS RA	Medi-care ADV	Medi-care ADV RA	Medic-aid	Medic-aid RA
2018	334.29	N/A	765.18	N/A	590.02	N/A	330.71	N/A
2019	341.72	367.44	756.20	667.92	707.09	549.14	417.86	206.86
2020	358.98	373.94	667.00	706.85	1114.49	673.15	443.49	216.34

- When we dig deeper into the data, we can see that increases in PMPM can be caused by an increase in resource use (defined by RVUs) and/or by an increase in unit prices (defined as allowed dollars per RVU). For example, when looking at non-risk adjusted Medicaid, we see a 26.4% increase in allowed PMPM from 2018-2019. This includes a 12.0% increase in resource use (defined by RVUs) and a 12.8% increase in unit price (defined as allowed dollars per RVU). The increase in resource use may be explained by the addition of the Medicaid expansion population in 2019. By comparison, the commercial population saw a very small increase (2% in allowed PMPM) and the Medicare FFS population saw a very small decrease (1% of allowed PMPM).

ALLOWED PMPM BY REGION AND INSURANCE TYPE

COMMERCIAL

Region	2018 PMPM	2018 PMPM RA	2019 PMPM	2019 PMPM RA	2020 PMPM	2020 PMPM RA
Central	347.36	N/A	401.67	397.14	372.49	371.92
Eastern	389.61	N/A	302.73	428.25	277.41	271.90
Northern	261.64	N/A	314.62	358.05	393.75	451.61
Northwest	342.12	N/A	340.53	345.95	366.22	389.68
Southwest	459.01	N/A	401.61	312.28	367.71	364.37

MEDICAID

Region	2018 PMPM	2018 PMPM RA	2019 PMPM	2019 PMPM RA	2020 PMPM	2020 PMPM RA
Central	263.95	N/A	453.29	216.71	485.16	226.48
Eastern	393.74	N/A	415.44	219.90	438.10	213.84
Northern	302.39	N/A	362.25	204.35	397.23	259.21
Northwest	348.57	N/A	401.05	204.02	425.04	211.11
Southwest	331.65	N/A	448.42	189.23	465.86	186.22

MEDICARE FFS

Region	2018 PMPM	2018 PMPM RA	2019 PMPM	2019 PMPM RA	2020 PMPM	2020 PMPM RA
Central	781.98	N/A	778.82	825.29	687.63	728.65
Eastern	764.80	N/A	743.55	732.76	662.60	652.98
Northern	701.66	N/A	697.27	744.79	590.68	630.93
Northwest	859.06	N/A	858.41	1017.01	758.44	898.57
Southwest	728.79	N/A	716.86	731.87	639.68	653.08

MEDICARE ADVANTAGE

Region	2018 PMPM	2018 PMPM RA	2019 PMPM	2019 PMPM RA	2020 PMPM	2020 PMPM RA
Central	607.05	N/A	720.87	552.02	1078.39	648.57
Eastern	734.19	N/A	861.18	594.44	1107.55	675.59
Northern	442.50	N/A	507.99	533.48	1072.72	657.49
Northwest	553.57	N/A	706.74	551.67	1199.90	699.91
Southwest	685.59	N/A	895.97	617.81	1126.58	691.08

OBSERVATIONS FOR FURTHER REGIONAL ANALYSIS

- For those with commercial insurance from 2018-2020, we see significant increases in allowed PMPM, both with and without risk-adjustment, in the Northern region – and significant decreases in the Eastern region.

- For those with Medicaid coverage from 2018-2020, we see significant increases in allowed PMPM, both with and without risk-adjustment, in the Northern and Northwest regions. We also see what appear to be significant increases in allowed PMPM in the Central and Southwest regions, but these are minimized in the Central region and eliminated in the Southwest region when the MARA risk-adjustment is applied.

- For those with Medicare FFS coverage, we see a decrease in all regions in allowed PMPM, both with and without risk-adjustment from 2018-2020. But we must remember, this data does not include prescription costs.

- For those with Medicare Advantage coverage, we see significant increases in allowed PMPM, both with and without risk-adjustment, in ALL regions, with a particularly significant increase in the Northern region.

OBSERVATIONS FOR FURTHER ANALYSIS BY TYPE OF INSURANCE

COMMERCIAL

- Prescription drug costs overall decreased from 2018-2020. The allowed PMPM went from 102.53 in 2018 to 93.99 in 2019 to 79.25 in 2020.

- Outpatient expenses are increasing (75.55 in allowed PMPM in 2018, 95.48 in 2019, and 95.85 in 2020) while inpatient expenses are relatively stable (67.75 in 2018, 61.56 in 2019 and 61.77 in 2020).

- Professional expenses (inpatient procedures, radiology, pathology, etc.) are increasing (79.78 in 2018, 82.78 in 2109 and 113.67 in 2020).

- High cost imaging facility expenses doubled, from 3.98 in allowed PMPM in 2018 to 6.92 in 2020.

- Office administered drug expenses also increased significantly, from 9.39 in 2018 to 10.70 in 2019 to 16.72 in 2020.

- Physical therapy expenses, while modest, are also growing rapidly, from 2.33 in 2018 to 2.63 in 2019, to 4.04 in 2020.

MEDICAID

- Facility inpatient expenses increased from 98.34 in allowed PMPM in 2018 to 121.55 in 2019 to 129.06 in 2020.

- Prescription drug expenses increased even more dramatically - from 54.10 in allowed PMPM in 2018 to 66.04 in 2019 to 101.35 in 2020.

- Of the top cost drivers for Medicaid, in the "major services" category, 4 of the top 5 are prescription drug related.

MEDICARE

- While Medicare FFS did not experience increases in total cost of care between 2018 and 2020 (absent prescription drug cost information), we do see a few notable major service cost drivers worthy of attention. From 2018-2019, there was a 29.9% increase in the cost of physician office administered drugs. From 2019-2020 there was a 30.3% increase in the cost of hospital inpatient medical services.

TOP 5 CHRONIC CONDITION HEALTH GROUPER CATEGORIES FOR 2019

The data analysis also allows us to review the top chronic condition member cohorts with the highest spend out of the total allowed per member per month for each line of business*.

COMMERCIAL	MEDICARE ADVANTAGE	MEDICAID
103 – Cancer (13.6%)	103 – Cancer (17.2%)	104 - Renal failure (9.7%)
113 - Hypertension (10.1%)	104 - Renal failure (14.0%)	102 - Severe dementia (9.6%)
112 - Diabetes without CAD (8.6%)	113 - Hypertension (9.9%)	103 – Cancer (8.0%)
104 - Renal failure (8.6%)	112 - Diabetes without CAD (8.6%)	113 - Hypertension (6.8%)
138 - Healthy Female (16-40) (6.9%)	108 - Severe heart failure/ transplant/rheumatic heart disease/non-rheumatic valvular heart disease (7.3%)	101 - Major psychosis (6.7%)

* Medicare FFS is not included in this comparison due to lack of pharmacy data.

- While the condition health groupers differ somewhat in priority, we can see that cancer, renal failure, and hypertension cut across all three insurance types as a high spend category.

- Mental illness appears to be a more significant concern for Medicaid, with both severe dementia and major psychosis falling into the top five conditions for total spend allowed per member per month.

The Committee is very eager to add 2021 data to these baseline reports, and to expand the depth of its analyses, particularly as the data can be used to assist with objective C: Defining Payment Models with an Early Focus on Medicaid, detailed below.

C. DEFINING PAYMENT MODELS WITH AN EARLY FOCUS ON MEDICAID

BACKGROUND

The Payment Reform Committee worked to address the following task force aim: *Define payment models to better support primary care and support practice viability through systems that allow for predictability in financial support.*

Five basic questions were taken in to consideration when summarizing the research work and payment reform recommendations of the committee.

1. WHY IS PRIMARY CARE PAYMENT REFORM WORTH CONSIDERING FOR VA MEDICAID?

Evidence produced over the last 30 years and recently compiled into a widely read National Academies of Science, Engineering and Medicine report[4] makes clear the US health care system underinvests in primary care to the detriment of patients' life expectancies and communities' well-being. Primary care was further strained by the inequitable access, safety, and economic crises brought on by the Covid-19 pandemic, the reason for the Governor's Task Force creation in the first place. As we listened to the Task Force members' priorities and concerns while the state's health care system reacted and recovered, with some timely help from DMAS in mid-2020, it became clear that the pandemic had created conditions conducive to PCP payment reform by spreading awareness that: (a) independent primary care practices are disappearing and under considerable financial stress; (b) there is a congruence between a robust, re-tooled primary care sector and the General Assembly's desire to reduce avoidable ED and inpatient use while improving Medicaid outcomes; (c) a number of states have implemented primary care focused value based payment reforms within their Medicaid programs in recent years, in pursuit of similarly balanced quality improvement and cost containment goals.

4 National Academies of Sciences, Engineering, and Medicine. 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983

Since Medicaid now covers over 2 million Virginians[5], roughly 23% of the total population[6], including 826,000 children (38%), the program is large enough to leverage its influence for multiple objectives. It is worth remembering, however, that Medicaid payment rates for physician services are quite a bit below market and substantially below Medicare rates. A reasonable degree of payment increase or at least bonus possibility is likely necessary for value based reforms to be very effective in the Virginia Medicaid context.

2. WHAT VALUE BASED PURCHASING (VBP) ARRANGEMENTS ARE VIRGINIA MEDICAID MCOS USING NOW?

DMAS requires MCOs to report their VBP activities, and encourages non-fee-for-service payment models[7]. All 6 MCOs report some VBP activity, though for most of them, the initiatives are relatively new and quite small compared to total spend. As of June 2021, there were three types of VPB models in place: pay for performance bonuses (based on HEDIS measure scores, from claims data); upside-only shared savings (based on HEDIS Score thresholds being met and savings generated, with no downside risk); and direct infrastructure support, wherein insurers pay directly for care coordination personnel to work within physician practices. The latter is a de facto type of PMPM payment, enabling the provider to avoid downside risk while supporting care coordination.

3. WHAT ARE OTHER STATES DOING WITH VBP WITHIN THEIR MEDICAID PROGRAMS?

Investing in primary care is widely seen as a key step toward a robust, high-performing and efficient health care delivery system. Many states have implemented primary care payment reforms through Medicaid and other payers, and to date, nine states (RI, OR, ME, DE, WV, WA, VT, CO, CT) have either passed legislation or a budget clause to allocate more healthcare expenditure towards primary care. [8]

The following list includes highlights from the salient examples of implemented primary care payment model structures in Arkansas, New York, Colorado, Delaware, Oregon, and Maryland.

Arkansas' Payment Improvement Initiative (APII)[9]

Arkansas' reforms were executed in conjunction with Medicaid expansion using private plans in 2014, and in tandem with CMMI's Comprehensive Primary Care Initiative program. The APII had multi-payer participation, including Medicaid, MCOs, the State Employee Plan and Public School Employee Plan, and self-insured employers like Walmart. Quarterly performance updates were pushed to PCPs and practices through an online provider data portal, an essential infrastructure piece that was part of the APII program.

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5 DMAS Monthly Enrollment Report, May, 2022;

6 Population estimates taken from https://www.census.gov/quickfacts/fact/table/VA/PST045221?msclkid=b6d82eeed06a11ec9c30a3db16a2104a

7 Per May 2022 VBP updates provided by DMAS.

8 https://www.pcpcc.org/topic-page/state-payment-reform

9 https://www.ajmc.com/view/the-arkansas-payment-improvement-initiative-early-perceptions-of-multi--payer-reform-in-a-fragmented-provider-landscape

Payment Models:

Episodic Payment: PCPs may be rewarded, penalized, or remain financially neutral based on average costs for specific episodes in comparison to thresholds predetermined by payers. Reimbursement is through each payer's fee-for-service fee schedule. Shared savings are earned IF quality metrics hit. Episodes can be for events like pregnancy/childbirth, or for managing an acute situation, like post-hospitalization rehab.

Patient-Centered Medical Home (PCMH): Practices that participate as a PCMH receive a receive a monthly per member per month (PMPM) medical home support payment to facilitate care coordination and practice transformation.

New York's Delivery System Reform Incentive Payment Program (DSRIP)[10]

Authorized by a Medicaid section 1115 waiver, and completed in March 2020, NY's DSRIP goal was to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program to achieve the triple aim, and to reduce avoidable hospital use by 25% over 5 years. Up to $6.42 billion of non-fee-for-service dollars was allocated to this program with payouts based upon achieving system transformation results. Access to performance data and data analytics and MCO involvement early on were identified as contributing factors to the program's success.

Payment Model:

DSRIP providers are paid for achieving one of four types of milestones – Planning, Project Implementation, Reporting, Results. Many DSRIP projects had social determinant dimensions as well.

Colorado's Multi-Payer Patient-Centered Medical Home Pilot[11]

Completed in June 2012, the 3-year project was one of the first multi-payer medical home pilot, and laid the foundation for a significant expansion of support to PCMH in Colorado. The project involved 5 private health plans and the State's high-risk pool carrier, Cover Colorado. All participating practices were required to achieve at least level 1 PCMH recognition by the National Committee for Quality Assurance.

Payment Model:

Participating plans agreed to provide a per member per month care management fee to participating practices for up to 20,000 plan members in addition to traditional fee-for-service and a pay-for-performance bonus.

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10 https://www.medicaid.gov/medicaid/downloads/ny-dsrip-case-study.pdf

11 https://www.pcpcc.org/initiative/colorado-multi-payer-patient-centered-medical-home-pilot

Delaware's Patient Centered Medical Home Initiative[12]

Ending in 2015, this multi-stakeholder initiative was designed and launched through a partnership between the Medical Society of Delaware and Highmark Delaware. The initiative involved a multi-stakeholder leadership team, a physician advisory committee of statewide physician leaders and officials from each of the primary care specialty societies, and a management work group.

Payment Model:

> Enhanced payments to participating practices, plus additional bonuses to practices that met certain criteria benchmarks or NCQA PCMH certification in years 2 and beyond.

Oregon's Patient-Centered Primary Care Home Program[13]

Oregon Legislature HB 2009 established the Patient-Centered Primary Care Home Program in 2009. The goals were to develop strategies to identify and measure what a primary care home does, promote their development, and encourage Oregonians to seek care through recognized Patient-Centered Primary Care Homes.

Payment Model:

> Coordinated Care Organizations (CCOs) (which are also health plans) are required to provide PMPM payments as a supplement to other payments including FFS or value-based payments.

Maryland Primary Care Program (MPCP)[14]

This statewide voluntary program, modeled after CMMI's national Comprehensive Primary Care Plus Model (CPC+), is open to all qualifying Maryland primary care providers. It launched in January 2019 and was designed to span 8 years. The program was initiated by the Maryland Department of Health (MDH) in collaboration with CMMI, and operations are facilitated through the state Program Management Office (PMO).

The program objectives are to: reduce avoidable hospitalization and emergency department (ED) visits; build a strong, effective primary care delivery system to identify and respond to medical, behavioral, and social needs while contributing to lower Maryland's Medicare Part A and B expenditures by an annual saving target of $300 million by 2023.

Payment Model:

> Care Management Fee (CMF) - Prospective, non-visit-based payments per Medicare beneficiary per month (PBPM) paid quarterly in exchange for care management service adjustments

12 https://www.pcpcc.org/initiative/delaware-medical-home-pilot

13 https://www.oregon.gov/oha/HPA/dsi-pcpch/Documents/2020-PCPCH-TA-Guide.pdf

14 https://health.maryland.gov/mdpcp/Pages/home.aspx

Performance-based Incentive Payment (PBIP) – Annual prospectively paid and retrospectively reconciled performance-based incentive payment based on how well a practice performs on patient experience measures, clinical quality measures, and utilization measures that drive total cost of care

Payment under the Medicare Physician FFS Schedule –Track 1 continues to bill and receive payment from Medicare FFS as usual. Track 2 practices also continue to bill as usual, but the FFS payment for evaluation and management services are reduced to account for CMS shifting a portion of Medicare FFS payments into Comprehensive Primary Care Payments (CPCPs)

There are several common themes across the state implemented payment models detailed above. Each payment model involved multiple payers, which allowed for the ability to align payment and incentives across those payers. Most models included a PMPM payment not tied to performance to help supplement care coordination or care management activities. Also included in most models was a performance-based payment tied to specific quality metrics or pre-established criteria. These elements should be taken into consideration when discussing the development of a payment reform model for Virginia.

CMMI's Primary Care First Model[15]

The Centers for Medicare & Medicaid Services Innovation Center's (CMMI) Primary Care First model is a voluntary alternative five-year payment model that is based on the learning from and underlying principles of prior Comprehensive Primary Care Plus (CPC+) model designs. Primary Care First is currently offered in 26 regions, and includes two cohorts of participating practices, with Cohort 1 having launched in January 2021, and Cohort 2 in January 2022. Approximately 3,000 practices are participating in Primary Care First across both cohorts, and 24 payer partners are engaged. As of April 2022, 53 practices in Virginia are participating, with limited payer participation as Humana and Carefirst are the only two[16]. There are no published updates on additional payer participants in Virginia at this time.

Participating practices are led to and rewarded for delivering patient-centered care that reduces care provided in the hospital setting or reduces total cost. The hybrid structure for payments that are provided to practices include two major components:

1. Total Primary Care Payment (TPCP)

    Flat payments – encourage patient-centered care, and pays practices for in-person treatment through Medicare claims system, $40.82 base rate for each in-person visit, geographically adjusted

    Population-based payments – Prospective, per beneficiary per month (PBPM) payment based on practice risk group, provides more flexibility for providers to deliver care, allows for transition from fee-for-service payment, paid along with the flat primary care visit fee

15 https://innovation.cms.gov/innovation-models/primary-care-first-model-option

16 https://innovation.cms.gov/media/document/pcf-participants-april-2022

2. Performance-Based Adjustment (PBA)

   Paid on a quarterly basis in a lump sum, upside of up to 50% of model payment, downside of negative 10% of model payment, based on quality performance measures, incentive to reduce costs and improve quality

   Practices are eligible for a continuous improvement bonus (CI) of up to 16% of the possible 50% PBA amount if improvement target is reached

Primary Care First also prioritizes performance transparency by providing practices with identifiable performance data to encourage continuous improvement, with the ultimate goal being the reduction of patient health complications and overuse of high-cost care settings, leading to an increase in quality of care and decrease in spending. Virginia's participating practice sites span all five VDH Health Planning Regions. The two participating health plans in Virginia are Care First and Humana.

4. WHAT do we know and still need to know to design primary care payment options for Virginia Medicaid?

Total Medicaid spend for primary care services is around $344.6M a year. [17] Slightly over 50% of this total spend goes to PCP's practicing in groups of greater than 50. About 23% of this goes to PCP's practicing in groups of less than 10. Approximately 19% of this spend goes to FQHC's (both direct MCO payments and DMAS supported wrap around payments). These practice types are organized and function quite differently, as does pediatrics.

We have inadequate line of site to the following issues:

   The percentage of the PCP workforce that remains in independent practice, versus employed by health systems or in tight relationships with larger corporate entities. It is clear the number of primary care physicians in independent practice continues to decline.

   Within all practices, it is unclear how much "income derived by value based practice arrangements" ends up incentivizing the individual provider, versus being retained by the controlling structure of the practice. Indeed, given the preponderance of primary care physicians working in hospital systems or in large, multispecialty arrangements (CINs, ACOs, plus multispecialty practices) rather than small independent practices, perhaps the question should be, "How do we created a payment program where to earn the incentives, the controlling "structure" must invest in and incentivize primary care activities?"

17 These estimates are taken from internal data shared by DMAS and VH

It appears that many and likely a majority of primary care physicians participate in various external organizational structures that support value-based payment and care improvement activities. Examples include numerous Accountable Care Organizations (ACO), clinically integrated networks (CIN), and independent practice associations (IPA). These organizations engage in commercial insurance contracts as well as Medicare ACO arrangements and Medicare Advantage products.

Across all of the above practice and arrangement types we (and policy makers in Virginia) have little line of sight to geographic distribution generally and proximity to Medicaid recipients specifically.

5. WHAT would we recommend today, based on our learnings in the past year?

Recommendation 1: There is more to reform than money. We heard from numerous sources that Medicaid could be become a much better partner, less onerous to deal with from provider perspectives. Therefore, Virginia Medicaid should consider ways to reduce administrative burdens for participating providers.

Recommendation 2: One size will not fit all practice types in Virginia Medicaid. We would highly recommend developing separate payment models for Pediatrics, for FQHCs, for large or system-affiliated practices, and for small independent practices. We suggest this because pediatric patients are very different from adults in terms of quality metrics and cost reduction potential, because FQHCs are currently paid in a wholly different manner than other providers, and because value based incentives are more complicated to design to actually reach PCPs within systems compared to those that work in small independent practices. Minimum thresholds of numbers of Medicaid patients to participate should be considered as well, for administrative as well as statistical validity reasons.

Recommendation 3: This cannot be done without MCO participation. MCOs have implemented primary care VBP programs in provider agreements. DMAS has three options to pursue payment reforms: a centralized approach where DMAS standardizes the payment reform and directs MCOs to implements (i.e. a directed payment), or a decentralized approach (i.e. status quo) allowing MCOs to develop programs at their own pace or tailored to their unique circumstances. A centralized approach offers more uniformity to the providers through measurement, expectations, etc., but a decentralized approach may allow for more tailored and/or flexible programs.

Recommendation 4: Performance metrics could/should include quality, access, and cost or avoidance of negative care events. Quality and access, especially in relationship to cost, should be studied, as should continued efforts on trending primary care spend – both direct and in relationship to total cost of care via the Milliman/VHI reports developed this year.

Recommendation 5: Where possible, design should consider if payment and performance incentives can reasonably reach front line clinicians. The "art" of payment reform requires close coordination with MCOs and other organizations to accomplish shared objectives and credibly measure and reward impact.

D. DESCRIBING PRIMARY CARE INFRASTRUCTURE

BACKGROUND

The Primary Care Infrastructure Committee identified the following findings and potential focus areas to address the task force aim to: *Develop a plan to enhance primary care infrastructure support.*

A WORKING DEFINITION OF PRIMARY CARE

As we envision ways to enhance primary care infrastructure support, it will be helpful to have a working definition of primary care to focus and guide the work. Definitions do vary, but most overlap. As a working definition we suggest the following from the National Academies of Sciences, Engineering, and Medicine consensus study report on Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care (2021).

> *High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams that are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities. A key component of the model is that everyone, both adults and children, maintains an ongoing relationship with a team at the practice level, led by a personal primary care clinician that collectively takes responsibility for ongoing care.*

This working definition is aspirational in its description of what primary care should be. The implicit assumption is that work is needed to make the aspiration a reality across Virginia, and this will require enhancements to primary care infrastructure support.

A CONCEPT MODEL FOR ENVISIONING PRIMARY CARE INFRASTRUCTURE NEEDS

The committee introduced a set of key factors in the primary care landscape, as outlined in the accompanying text box. Each of these factors has a practical impact on the expectations for primary care, as well as the infrastructure needed to deliver high-quality primary care in response to these factors.

To summarize, the combination of stakeholder expectations, evolving population health needs, and emerging payment models is requiring primary care practices to develop core capabilities that are necessary for adapting to the changing landscape. The influence of these factors within a primary care practice can vary depending on the patient focus, the practice size and structure (e.g., independent, affiliated, publicly-supported), the payer mix, and the community setting. Consequently, efforts to enhance primary care infrastructure need to be differentiated to address particular practice settings. This need for differentiation is a key consideration in conceptualizing primary careinfrastructure needs, and for developing strategies to enhance primary care infrastructure support.

While keeping in mind this need for differentiation, we offer a generalized model as a starting point for envisioning primary care infrastructure needs. This is an evolving draft of a model we have previously shared with the committee and the full Task Force.

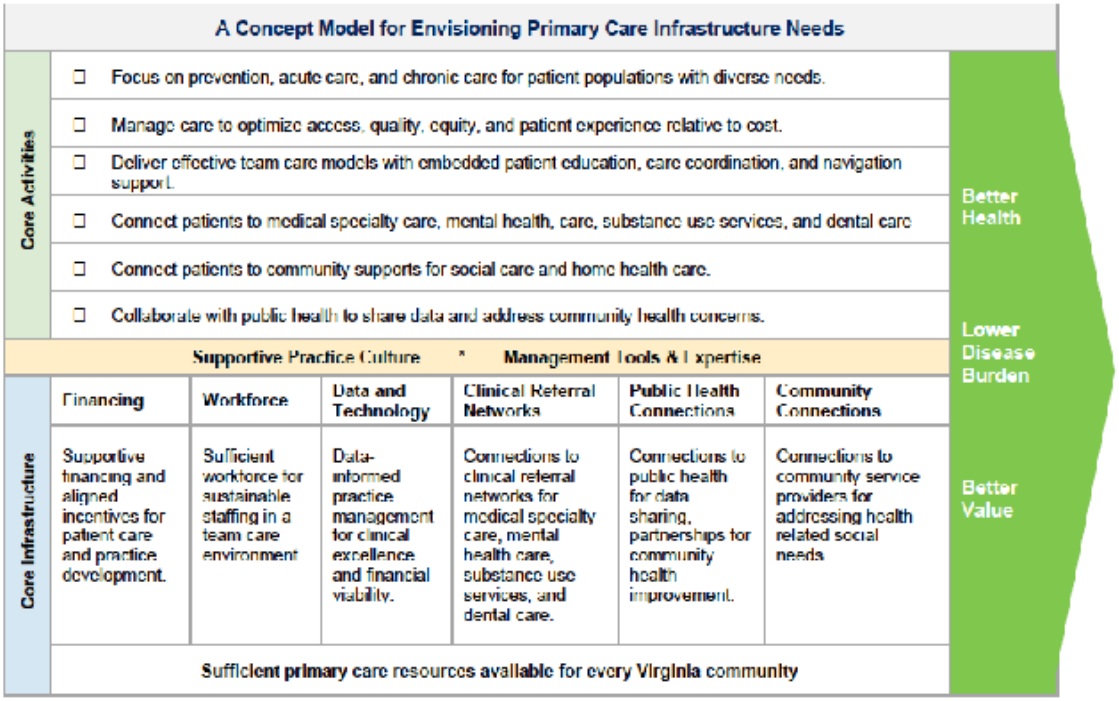
The format shown on the next page is a variation on a 'value chain diagram' designed to illustrate the relationships between core activities and required supports.

- In this particular model, the core activities include the essential things primary care practices are being asked to do in the emerging primary care landscape.

- The core infrastructure elements include essential resources and capabilities necessary to deliver the core activities.

- A supportive practice culture and management tools & expertise are bridging factors that supports sustainable practice over time. A supportive practice culture that promotes individual and team wellness is essential for addressing the high levels of stress and burnout occurring in primary care practice settings. Management tools & expertise are essential for clinical management, financial management, human resource management, and other aspects of effective practice management.

- The envisioned value impact of the core activities and associated infrastructure include better population health, lower disease burden, and better value for Virginia.



FRAMING A PLAN TO ENHANCE PRIMARY CARE INFRASTRUCTURE SUPPORT

The concept model outlined above can help us focus our efforts in developing a plan to enhance primary care infrastructure support. As we begin to frame this plan it is helpful to keep some guiding insights in mind.

- **Primary care is under pressure**. Concerns were being raised about the long-term viability of primary care before the pandemic. Most recently, interviews with primary care leaders and survey research conducted by the Ambulatory Care Outcomes Research Network at VCU Health indicate that many primary care practices are struggling to gain and sustain the financial and human resource necessary to deliver high-quality care within a viable business model. This has important implications for Virginia communities, especially as pandemic-related funding and supportive regulations are removed from Medicaid and other health-related programs.

- **Continuous learning and improvement is essential.** All primary care practices are continually evolving to address the changing needs and expectations of patients, communities, service partners, payers, the workforce, accreditation agencies, and public policy. This requires access to the right kinds of knowledge, data, tools, training, technical assistance, and strategy coaching.

- **Support needs vary by practice setting**. The capabilities and support needs of primary care practices can vary widely based on patient mix, size, structure, payer mix, existing affiliations, and community settings. This means any suppo platform must be flexible and differentiated to support the diverse needs of primary care practices.

- **Support resources are substantial but fragmented.** As outlined in our March 29 memo, we have an opportunity to think broadly about a wide range of resources that could potentially help enhance primary care infrastructure support. We developed the list outlined below as a starting point for thinking about the possibilities. These resources are substantial, but they are not necessarily aligned in ways that provide synergy for primary care practice development.

A Working List of Potential Resources for Enhancing Primary Care Infrastructure Support	
• Internal resources of primary care practices • Parent organizations of primary care practices • Virginia primary care associations • Managed services organizations (MSOs) • Population health management companies[1] • Independent practice associations (IPAs) • Clinically integrated networks (CINs) • Accountable care organizations (ACOs) • Virginia health systems • Virginia health plans • Virginia employers (including state government) • Virginia colleges, universities, and academic health centers	• Virginia health foundations / philanthropy • Virginia Health Information, Inc. • Virginia local governments • Virginia economic development agencies • Virginia Health Workforce Development Authority • Virginia Department of Health • Virginia Department of Medical Assistance Services • US Agency for Healthcare Research and Quality • US Centers for Medicare and Medicaid Services • US Health Resources and Services Administration • Other federal agencies • National foundations / philanthropy • Virginia Center for Health Innovation

- **Innovation is everywhere.** The really good news is Virginia primary care practices are led and staffed by some brilliant people. Primary care practices are innovating every day to solve the types of challenges identified by the subgroup and the broader Task Force. If these innovations could be captured and spread as promising practices, the results could be transformational for practices that need tested ideas for solving challenges.

- **Public partnership matters.** Primary care practices can do a lot on their own, but there is a real need for public policy support for primary care development. There is a compelling public interest in assuring that sufficient primary care resources are available for every community across Virginia. There is also a need for public sector partnerships to help support primary care development through (at a minimum) viable payment models, workforce development, and public health partnerships.

A CONCEPT FOR A PRIMARY CARE INNOVATION HUB

One option to consider for enhancing primary care infrastructure support would be a 'primary care innovation hub' for Virginia.

- **Purpose**. The purpose of the hub would be to help Virginia primary care practices develop the infrastructure supports needed to deliver excellent primary care in a value-based payment environment.

- **Members**. Membership in the hub would be open to any organization providing primary care in Virginia. Membership could also be open to primary care support organizations such as associations, clinically integrated networks, IPAs, MCOs, and other interested organizations.

- **Supports.** The hub would support primary care practices by routinely developing and sharing knowledge, data, tools, training, and technical assistance for primary care practice development, differentiated by practice size and structure. The hub would also invite members to inform public policy education related to primary care payment models, workforce development, public health partnerships, and other relevant public policy initiatives.

- **Innovation Model**. Members would be invited to ask for specific types of ideas, learn from other hub members, share their own expertise, apply models that fit their practice setting, and spread innovations that work. The hub would tap the collective wisdom of the members in addition to seeking expertise and promising practices from across the field. This would give hub members an opportunity to learn from peers in addition to sharing their own insights and ideas for innovation.

- **Differentiation**. The hub would acknowledge the need to differentiate support resources by practice focus, size and structure, and strive to deliver supports in ways that recognize these differences.

- **Partnership**. The hub would not seek to displace existing sources of support for primary care practices such as associations and various types of clinical support organizations. The objective would be to engage these organizations as partners in identifying and spreading what works among primary care practices of all shapes and sizes across Virginia.

- **Structure**. The hub could be supported by a small staff team and housed within an appropriate organizational location with basic infrastructure for management. By utilizing technology to communicate and deliver supports, and tapping expertise from the field on a project-by-project basis, the network support team could operate efficiently with a relatively flat organizational structure. Funding could be provided by a combination of grants, contributions, and public funds.

- **Results**. The hub would be judged on results, including productivity in identifying and spreading practice innovations, impact on public policy supports for primary care, the number of primary care practices reached, and the satisfaction of hub members.

NEXT STEPS

In this summary report we offer an outline of a concept for enhancing primary care infrastructure in Virginia by creating a Virginia Primary Care Innovation Hub. This will be a key deliverable for years 3 and 4 of the task force work.

E. IDENTIFYING MARKERS OF HIGH VALUE CARE

BACKGROUND

In order to more closely align payment and value, the task force recognized the need to improve consensus on the markers of high value care and to ensure that these markers are implemented in Virginia's value-based payment contracts. Specifically, the performance measurement committee was tasked with ensuring:

The viability of primary care practices is safeguarded, primary care payment is predictable and tied to meaningful performance measurement in order to advance better health care value, and primary care is less susceptible to changes in the economy.

YEAR 1:

The performance measurement committee was tasked with the following: a) finalizing performance measurement aims and indicators, b) identifying measures to correspond to the selected aims and indicators, c) approving a final set of measures, and d) developing a measure adoption plan for all Virginia entities, including securing relevant participation agreements if necessary.

During year one, staff and committee members worked to define an ideal state of primary care from the lens of different stakeholder perspectives. A comprehensive grid was created to capture the perspective of patients, clinicians, employers, and health plans. Details were provided by committee members from their personal perspectives on the following measurement criteria categories: access; affordability and smarter spending; professionalism; population health; quality and safety. After an in-depth analysis of the information gathered on the grid, the group reached a bottom line consensus of seven recommended measurement needs.

7 Measurement Categories:

1. Person-Focused Primary Care Measure (Access, Continuity, Comprehensiveness, Coordination)
2. Person-Centric Diversity and Health Equity Measure (Barriers of Race, Ethnicity, Language)
3. Person-Centric Health Literacy Measure (Individual confidence in managing health)
4. Patient Reported Cost Burden Measure (Co-pays, deductibles, medications)
5. Primary Care Clinician Measure (Administrative burden, Data Access, Burnout)
6. Accountability Measure between Employers and Health Plans (Network, Plan designs, Educational tools)
7. Clinical Competency Assessment (Training, Licensing, and Certification vs. Other)

Also noted was the importance of considering a total cost of care measure, which the Spend Reports Committee has taken the lead on identifying.

YEAR 2:

Year 2 of the committee's work involved identifying a Virginia primary care core measures set with defined pathways for new measure adoption. After significant research, staff selected specific measures to correspond with the agreed upon measurement need categories identified in year one. Following in- depth discussion on each measure's technical specifications, gathering preliminary feedback from health plans on their new measure adoption processes, and reviewing examples of successful implementation of measurement pilots nationwide, committee members reached consensus on the following recommended approach and final set of measures.

Recommendation 1: Reduce current clinical quality measurement burden

Recommend that health plans limit required reporting of quality measures to those taken from the CQMC Consensus Core set[1817] and mutually agreed upon by the Health Plan and the Hospital System/Clinician.

Recommendation 2: Identify and deploy pilot instrument/measures that cover most of the identified measurement categories

- *Recommend piloting the Person-Centered Primary Care Measure[1918] + What Matters Index[2019] as a streamlined instrument.*
- *Look at the Physicians' perception of autonomy[2120] as a standalone measure or explore alternatives.*
- *These would not be tied to payment initially to encourage adoption and to provide the opportunity to create a baseline*
- *Committee has reached consensus that the pilot should have multi-payer participation, and regional health system representation, including 1 urban and 1 rural system.*

NEXT STEPS

Reduction of current measurement burden

The committee has encouraged task force health plan members to research and report back on the feasibility of transitioning to the CQMC Core Measure set as outlined under "recommendation 1" above. Plan members have begun this process, with an eye toward the success of the PCPM pilot as a key influencer in their efforts.

[1817]CQMC Consensus Core Set: ACO and PCMH/Primary Care: http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=88907
[1918]Larry A. Green Center Person Centered Primary Care Measure: https://www.green-center.org/pcpcm
[2019]John H. Wasson's What Matters Index: https://link.springer.com/article/10.1007%2Fs11136-017-1573-x
[2120]Physicians' perceptions of autonomy support during transition to value-based reimbursement: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7112234/17

Pilot Implementation

There is significant support and alignment among task force members, other Virginia-based organizations, and national organizations to pilot the PCPCM. We have identified a number of health system and clinically integrated network (CIN) partners willing to serve as pilot sites for the PCPCM. Additionally, staff have informed health plan representatives on the task force of the proposed pilot to solicit feedback and gauge receptivity. Participation by both provider and health plans is essential to the success of adopting meaningful performance measurement, driving improvement in primary care, and advancing better health care value overall. The proposed rollout of the PCPCM through the Virginia Task Force on Primary Care could be easily scaled from this pilot to statewide depending on funding availability.

F. PROMOTING INNOVATIONS IN TELEHEATH

While the Virginia Task Force on Primary Care did work to promote telehealth innovation in its first year (see recommendations and impact above), it soon learned that the Virginia Department of Health (VDH) was also engaged in this work, through its required oversight of the State Telehealth Plan (https://www.vdh.virginia.gov/commissioner/board-of-health/state-telehealth-plan/). We continue to monitor other states work in this area (see attachments E and F) and to share them as appropriate with VDH leadership.

CURRENT ACTIVITIES

For Year 3, which launched in July of 2022, our committee workplans are as follows:

Spend Reports and Data Analytics:

- Update Total Cost of Care and Primary Care reports to include additional year data
- Refine methodology to address data inconsistencies across payers and provide key data points for policymakers
- Conduct additional analyses on impact of COVID-19 and other trend analyses of interest (e.g. behavioral health, urgent care)
- Develop one-pagers and web content for sharing findings publicly and with policymakers
- Pilot a Virginia Primary Care Scorecard as part of Robert Graham Center collaboration

Performance Measurement:

- Pilot the Patient-Centered Primary Care Measure and the What Matters Index in Virginia primary care practices and evaluate the success of these measures for national implementation (If additional practice supports are needed to address practice deficiencies in these new measures, identify those in FY'24)

- Encourage and document health plan Core Quality Measures Collaborative measure adoption.

- Explore and report on the feasibility of physician autonomy and employer/health plan accountability measures

Payment Reform:

- Assist, as requested, Virginia Medicaid with payment reform model design and building a data infrastructure within DMAS to support analytics and to undergird policy choices

- Develop and issue a request for information (RFI) from the task force to MCOs, medical groups (for adult and pediatric primary care), ACOs/CINs, FQHCs, and independent physicians about preferred payment models, including incentives, performance and outcomes measurement strategies as well as suggested infrastructure improvements that respondents believe would improve access, outcomes and satisfaction for patients and providers alike

Clinician Retention and Well-Being:

- Build a collaborative network of leaders and organizations committed to strengthening the culture of health care team well-being across Virginia's entities and better retain Virginia's health care workforce

- Identify and leverage existing resources and share best practices in order to better advance health care team well-being and retention

- Develop standards of care and provide guidance for health care team well-being within Virginia

- Establish a plan for funding and implementing needed improvements

Additionally, we have launched a new online platform, the Virginia Primary Care Innovation Hub (https://pcinnovationhub.mn.co/), which supports the connectivity and work of all our committees and the overarching task force.

FUTURE WORK

For Year 4, which will begin July 2023, our committee workplans are as follows:

Spend Reports and Data Analytics:

- Update Total Cost of Care and Primary Care reports to include additional year data
- Consider inclusion of non-claims based data
- Consider inclusion of quality indicators
- Launch pilot to provide 500 Virginia primary care practice sites with NPI-specific quarterly total cost of care reports

Performance Measurement:

- Report on the feasibility of Virginia utilizing the proposed primary care core measure set in value-based payment contracting

- Launch Smarter Care Virginia: Improving Vaccination Rates initiative. 500 primary care practices will be enrolled and will be provided with NPI specific, real-time, v accination performance reports from ImmuTrak

Payment Reform:

- Report detailing best practices in Medicaid data infrastructure and analytics

- Report detailing payment mechanisms and performance measures Medicaid might benefit from using in future contract negotiations

Virginia Association of Health Plans Report

to the

Governor's Task Force on Primary Care

Mr. Doug Gray, Executive Director

March 2021

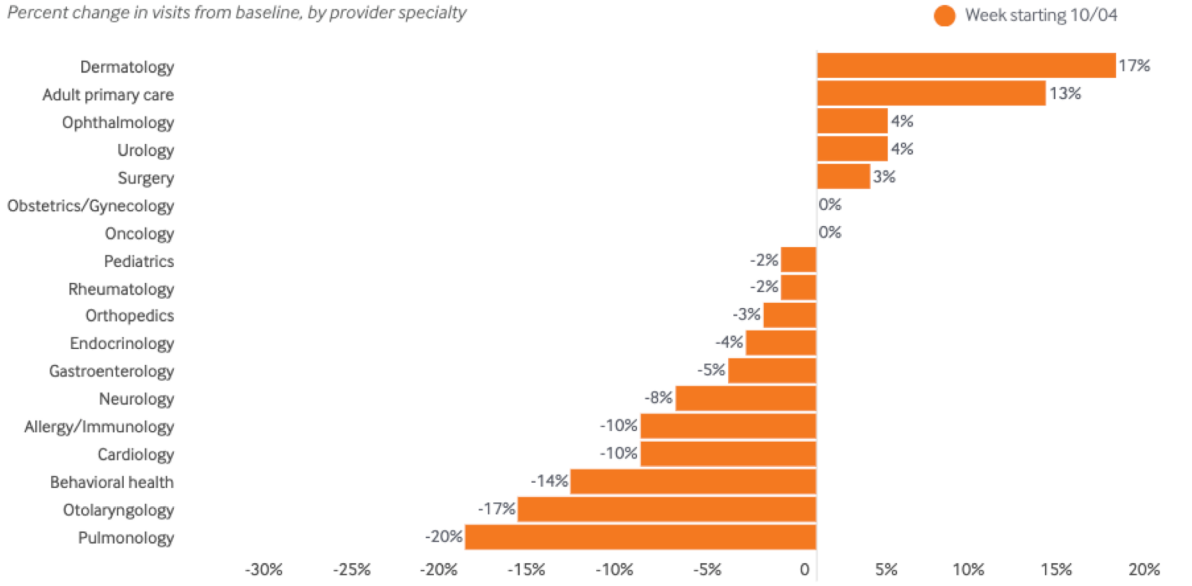
Summary

- Since the beginning of the Public Health Emergency (PHE), Virginia's health plans have been dedicated to ensuring quality care for members by rapidly providing flexibilities to health care providers, including primary care. The plans:
  - Eliminated barriers to care by waiving cost shares
  - Provided many virtual care options
  - supported providers by extending flexibilities, removing as much administrative burden as possible, and providing financial assistance to customers, employers, and providers.
  - Provided direct financial and charitable supports to the communities they represent.

Utilization Context

Reports indicate that utilization has returned to pre-pandemic levels.

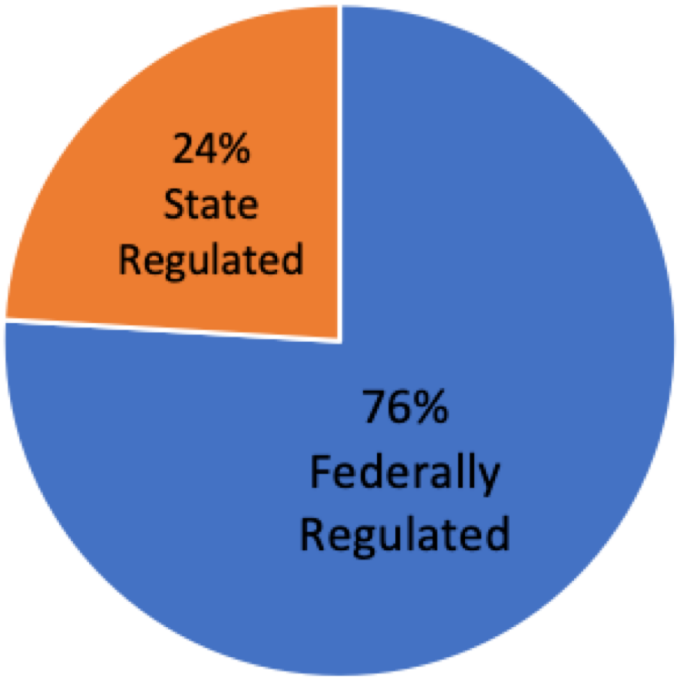
Weekly visits to dermatologists, urologists, and adult primary care physicians, among other specialists, are exceeding the prepandemic baseline. But weekly visits to certain other specialists, including pulmonologists and behavioral health providers, remain substantially below their baseline.

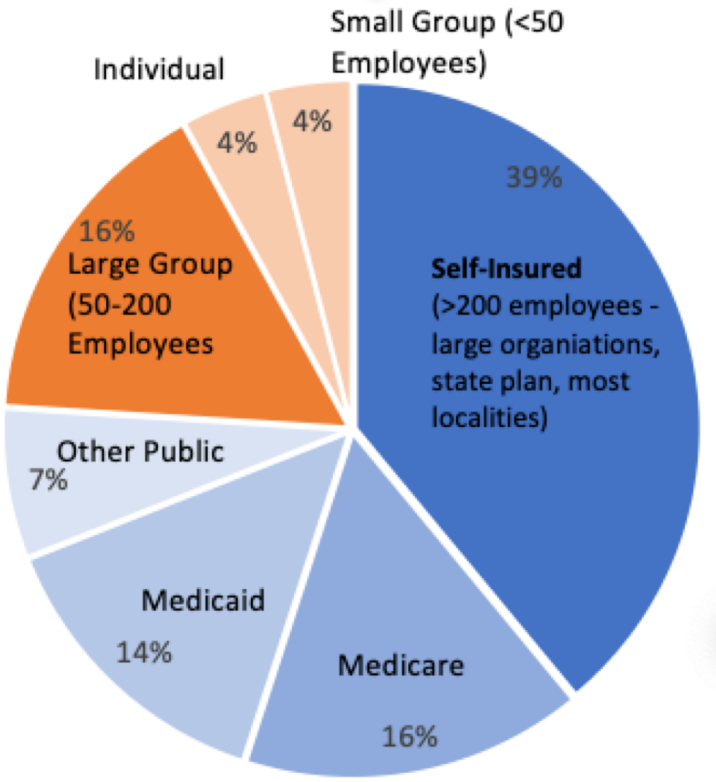


Data are for the week of October 4–10 compared to the baseline week (March 1–7). Data are for only the selected specialties shown. The decline in visits is reflective of all visit types — in-person and telemedicine. Visits from nurse practitioners and physician assistants are not included. Urgent care center visits are not included in adult primary care or pediatrics.

Source: Ateev Mehrotra et al., *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

How are Virginians Covered?





State law affects Virginians with **individual**, **small group**, and **large group** coverage. **Self-insured coverage**, **Medicare**, **Medicaid**, and other public plans like **Tricare** are regulated at the federal level.

Context for Savings from Reduced Utilization

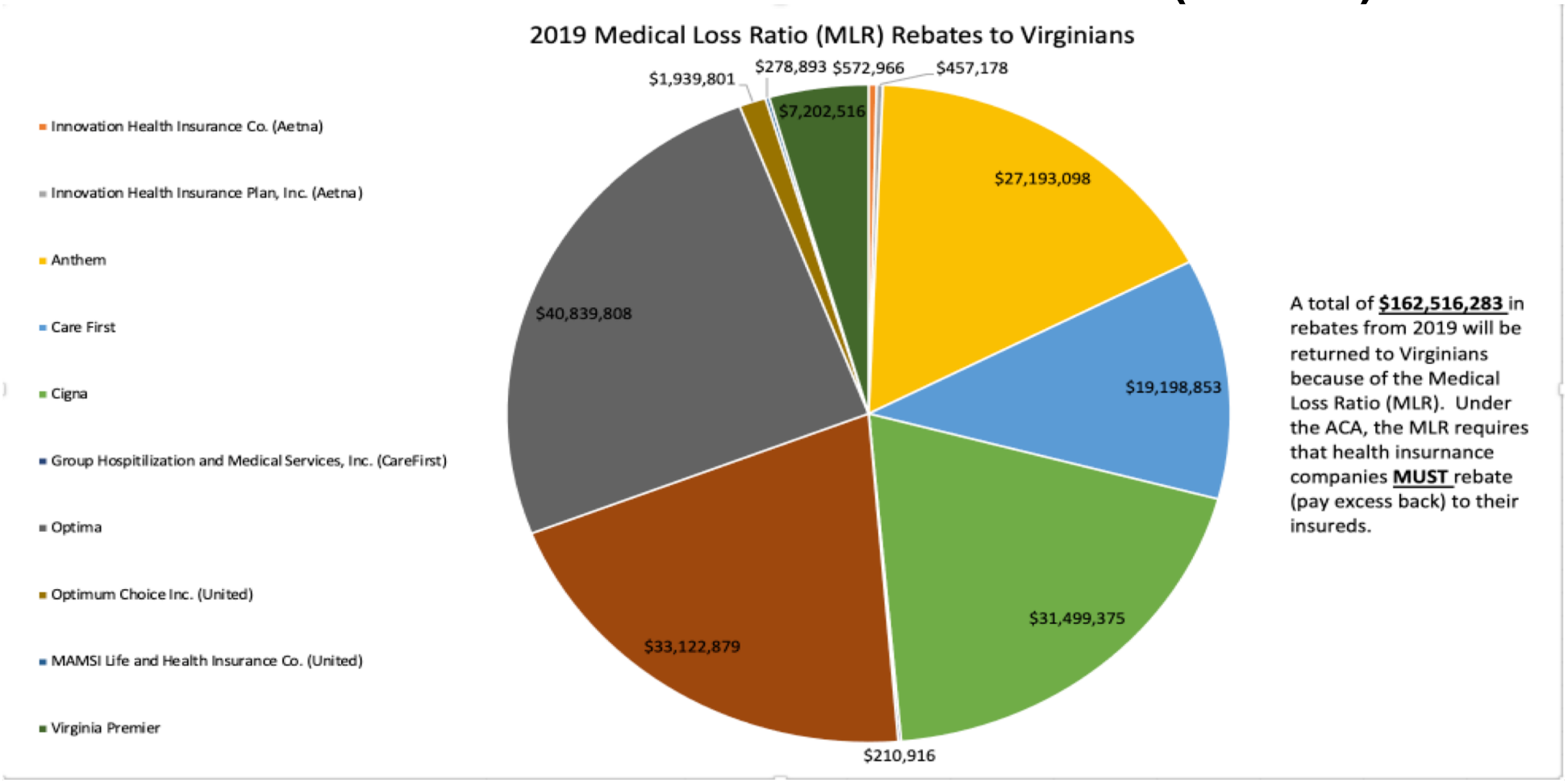
- Virginians get their coverage from three main sources:
  - Government
  - Self – Insured Market
  - Fully – Insured Market
- How are savings realized?
  - Government → Government
  - Self – Insured Market → Employer
  - Fully – Insured Market → Customer/Employer

Health Plans are required to distribute savings to the customer

Medical Loss Ratio (MLR)

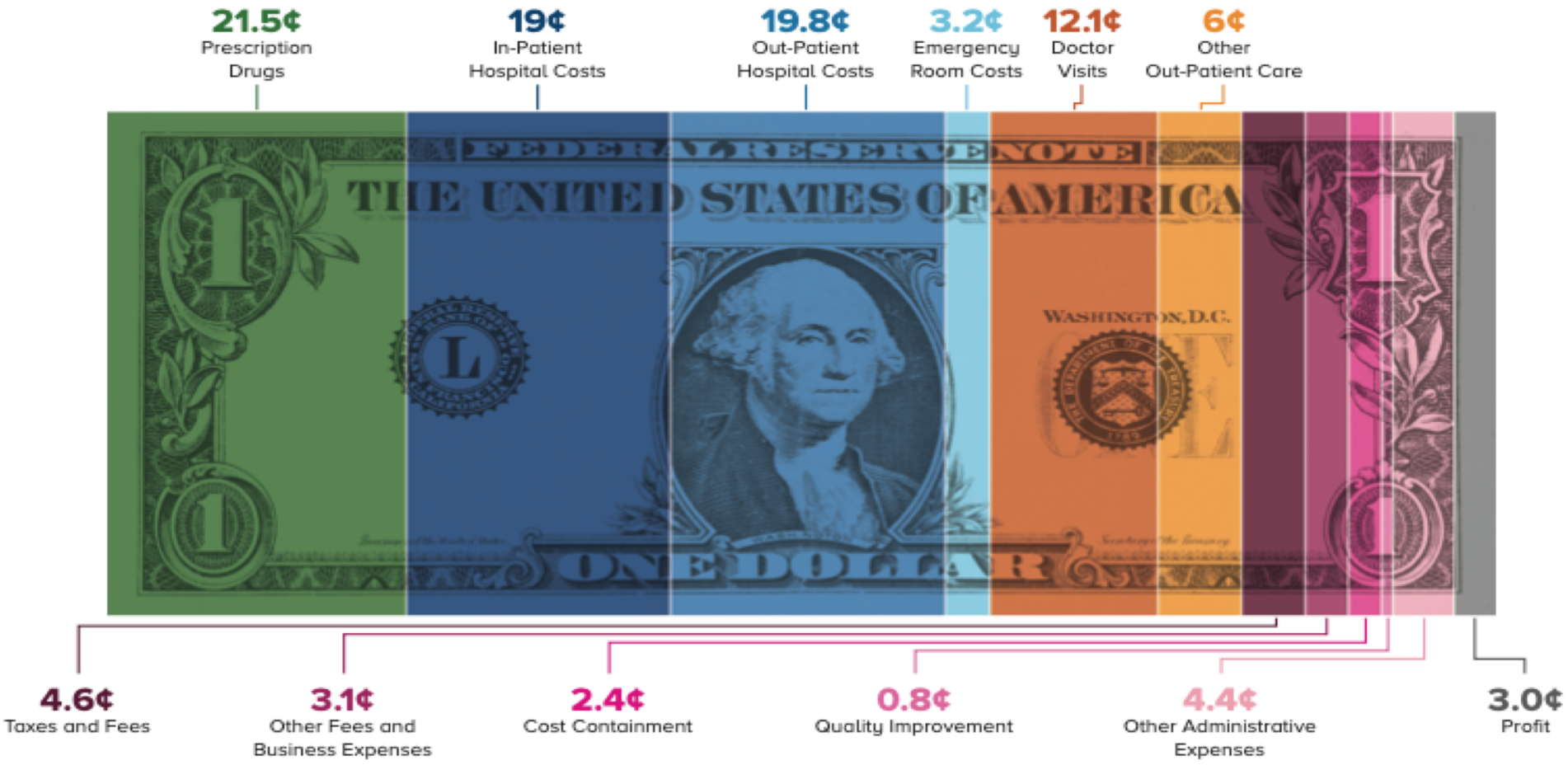
- Health insurance company profits are capped by federal and state law and are the only health care entity with a **profit cap or Medical Loss Ratio (MLR)**
- 80-85% of all premium revenue MUST be spent on **medical claims**
- Care coordination, disease management, taxes and fees, administrative expenses, and company profit must come from the remaining 15-20%

Medical Loss Ratio Rebates (MLR)



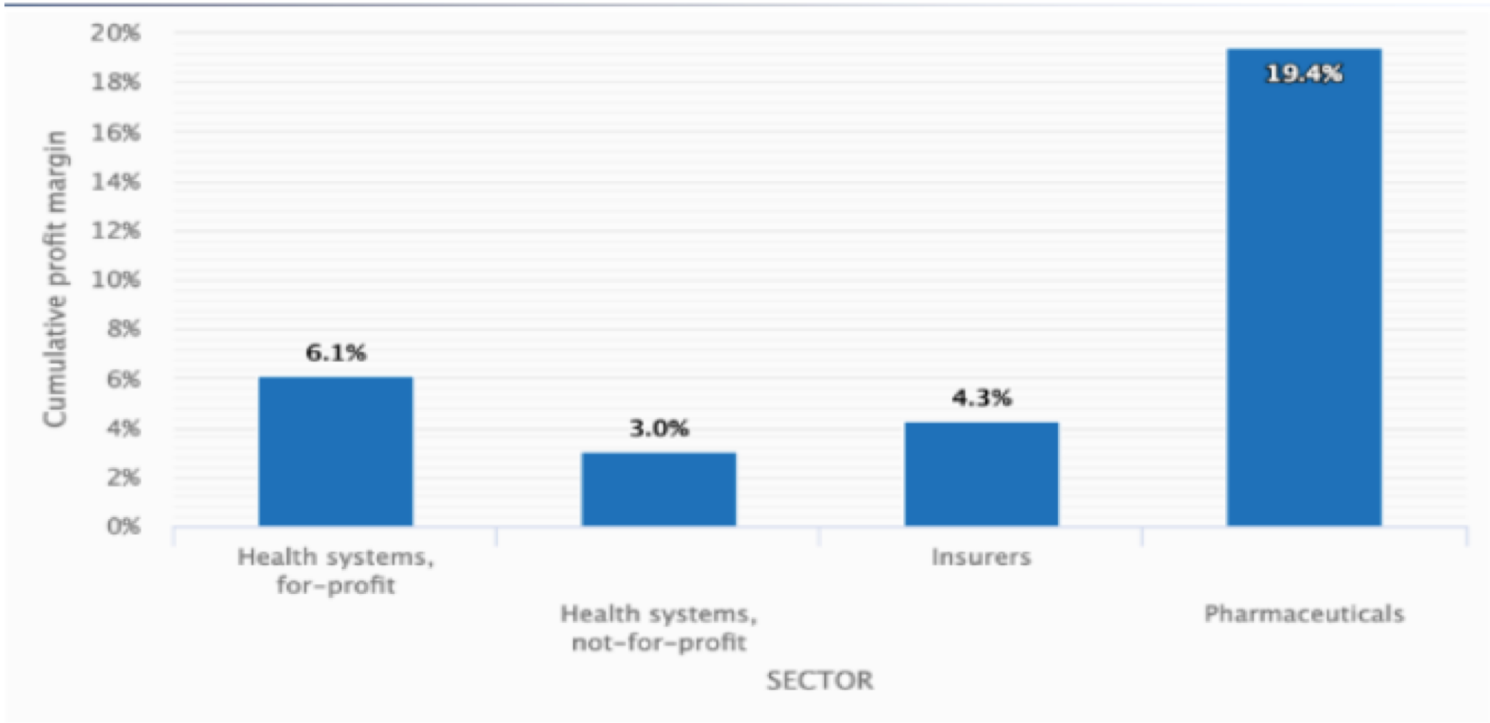
Source: Center for Medicaid Services (CMS) Issuers Owing Rebates for 2019

2020 AHIP Health Care Dollar



Source: https://www.ahip.org/health-care-dollar/

Profit Margins



*"Drivers of US Health Care Spending" by Jaime S. King, JD, Phd, UC Hastings Law School." Presentation made to NCSL August 8, 2019

Recommendation 1: Virginia's health plans voluntarily implement one or more of the following options for their commercially fully-insured and willing self-insured customers:

A. Extend Telehealth Provisions of HB 5045/SB 5080
B. Reimburse CPT 99072 at rate not below $6.57 for the latter duration of the PHE or Dec. 31, 2020.
C. Pay each PCP $2PMPM for patients attributed to them by current methodologies, starting as soon as feasible and for one year or the duration of the PHD, whichever is longer, IF the PCP agrees to a contract wherein, within one year of the end of the PHE, the PMPM amount or other non-FFS payment will depend upon performance on quality, patient experience, and total cost of care metrics.
D. Implement an enhanced FFS payment plan that would apply to all PCPs and pay all FFS evaluation and management CPT codes at 110% of current rates, starting as soon as possible and continuing for one year or the duration of the Public Health Emergency, whichever is longer.

Recommendation 1A

- Under current law, a telehealth video visit would be paid at the same rate as an in-person visit. Plans are voluntarily paying for audio only visits throughout the crisis, but not at the same rate as an in-person/telehealth visit.

- All of the plans are complying with state law extending the telehealth provisions from HB 5046. Plans have been, and continue to, support telehealth visits with a provider and continue to reimburse for telemedicine services regardless of the originating site or whether the patient is accompanied by a health care provider.

- Plans have greatly expanded access to telemedicine throughout the duration of the pandemic and continue to evaluate telemedicine practices that may support member access to care, including primary care.

Recommendation 1B

- The majority of plans responded they did not reimburse for CPT 99072 at rate not below $6.57 for the latter duration of the PHE or through Dec. 31, 2020. However, two MCOs did implement.

Recommendation 1C

- No plan implemented.

- While plans generally haven't given increases in the fee schedule or PMPM payments, for PCPs in value-based programs plans are using the better of the past two year's scorecard results to determine the highest bonus payout. This prevents providers from being adversely impacted during the public health emergency and resulted in higher overall payouts.

- Some plans only provide PMPMs under Care Collaboration programs and the PMPM may be less than $2, depending on the provider. These programs are not universally offered to all providers and are only offered to those who have the infrastructure to engage and support in improving member outcomes.

Recommendation 1D

- MCOs implemented a temporary enhanced FFS payment rate, at the request of DMAS, to reimburse specific evaluation and management codes at 29% increase for all Medallion 4.0 members. One MCO reported the total cost of that 29% increase was **$6,810,135.**

Recommendation 2

- **Virginia's health plans, with assistance from the Virginia Association of Health Plans, submit a report to the Governor's Task Force on Primary Care no later than February 1, 2021 detailing the specific financial support each provided to Virginia primary care clinicians to address pandemic issues from March 1, 2020 through December 31, 2020. This data will be utilized to better inform long-term task-force recommendations. This report would include, but is not limited to data pertaining to increases in FFS rates, PMPM, PPE CPT code reimbursement, and expansions in telehealth coverage.**

Recommendation 2 – Assistance to Providers

- Telephone-only services covered (Medicaid and Commercial)
- Relaxed some timely filing provisions (Medicaid and Commercial)
- Extension of Authorizations for many services (Medicaid)
- Suspended some OON requirements (Medicaid)
- Extensions in continuation of services for member appeals (Medicaid)
- Increased payments to nursing facilities, $20 per diem, per resident (Medicaid)
- Removed all COVID-19 prior authorizations
- Permitted online mental health counseling to all members at in-network providers
- Offered Provider Grants
- Financial Assistance (0% interest loans) to 244 groups

Recommendation 2 – Assistance to Employers/Members

- Provided a one-month premium credit to individual and fully insured employer customers ranging from 10-15 percent
- Worked with some employer groups on special payment arrangements as a bridge to continue to provide insurance for their employees
- Waived all cost sharing for COVID-19 diagnosis and treatment
- Allowed 90-day supply for pharmacy
- No premium changes for reduced workforce
- Provided early refills, prolonged authorizations and increased home delivery options of medication to ensure no shortages, extended hours at our behavioral health pharmacies to ensure medication adherence for those with mental health and substance use disorders.
- Allowed grace periods for employers and individuals to pay premiums.
- Opened a special enrollment period to allow commercial customers to add employees who previously declined health benefit coverage

Recommendation 2 – Assistance to Community

- We volunteered more than 14,100 hours and matched $854k to support more than 500 Virginia charities in 2020.
- Grants to community and faith-based organizations
- Opened free access to our mental health mobile app and 24/7 emotional support phone lines to help all Americans cope with mental health impacts during the COVID-19 pandemic.
- Continued to expand access to COVID-19 testing, establishing testing sites nationally, including approximately rapid-result sites.
- Provided donations of PPE and food to various homeless shelters, food pantries/food banks
- Delivered food for those in need for Hospitals and other nonprofit organizations
- Provide School Supplies and hygiene items for Back to School children
- Launched a $5 million public-private sector philanthropic initiative

Recommendation 2 – Charitable Contributions

- Established a COVID relief fund for community support and direct care services during COVID.
- Provided COVID screenings to the community free of charge.
- Our Foundation provided $25 million in financial support in the form of charitable relief grants to support the families of healthcare workers who lose their lives to COVID-19.
- Support for non-profit pharmacy: $50,000 to provide free prescription medication to uninsured patients who are facing economic crises due to the pandemic
- Community Foundation for Northern Virginia: $60,000 to provide block operating grants that will be awarded to local nonprofits
- Supported numerous organizations with charitable contributions (Arc of Piedmont, Harrisonburg and Rockingham; NAMI; United Way of Richmond, Petersburg and Northern VA; WARM Shelter)
- Our Foundation released funding of $963,000 to support COVID- 19 pandemic response efforts
- We have given a total of $642,000 in to support a range of local health care related causes in Virginia
- Provided more than $100 million in support to date to those affected by COVID-19, including hot spot relief efforts, health workforce safety, seniors and individuals experiencing homelessness and food insecurity.

POLICY AND PAYMENT OPTIONS FOR PRIMARY CARE PARITY AND PER-MEMBER PER-MONTH PAYMENT MODELS IN PRIMARY CARE

Prepared for the Governor's Primary Care Task Force

Agenda

- Overview of Aims and Objectives
- Payment Parity with Medicare
- Per-Member Per-Month Payment Models
- Approaches to Achieve High-Value Care

OVERVIEW OF AIMS AND OBJECTIVES

Aims of the Governor's Task Force

- ✓ Build a stakeholder coalition to direct primary care support and advance the use of data/communication systems for action;
- ✓ Define payment models to better support primary care and support practice viability through systems that allow for predictability in financial support;
- ✓ Describe the infrastructure needed to support primary care;
- ✓ Identify markers of high value care in the COVID and post COVID era to function as quality metrics; and
- ✓ Promote innovations in telehealth, population health management, and outreach to adapt to the changing COVID environment.

Objective Outlined by Task Force for DMAS

- ✓ DMAS to draft a report detailing anticipated impacts of:
  - Paying for Medicaid primary care services at parity with Medicare, and
  - Implementing a per-member per-month (PMPM) model for Virginia Medicaid.

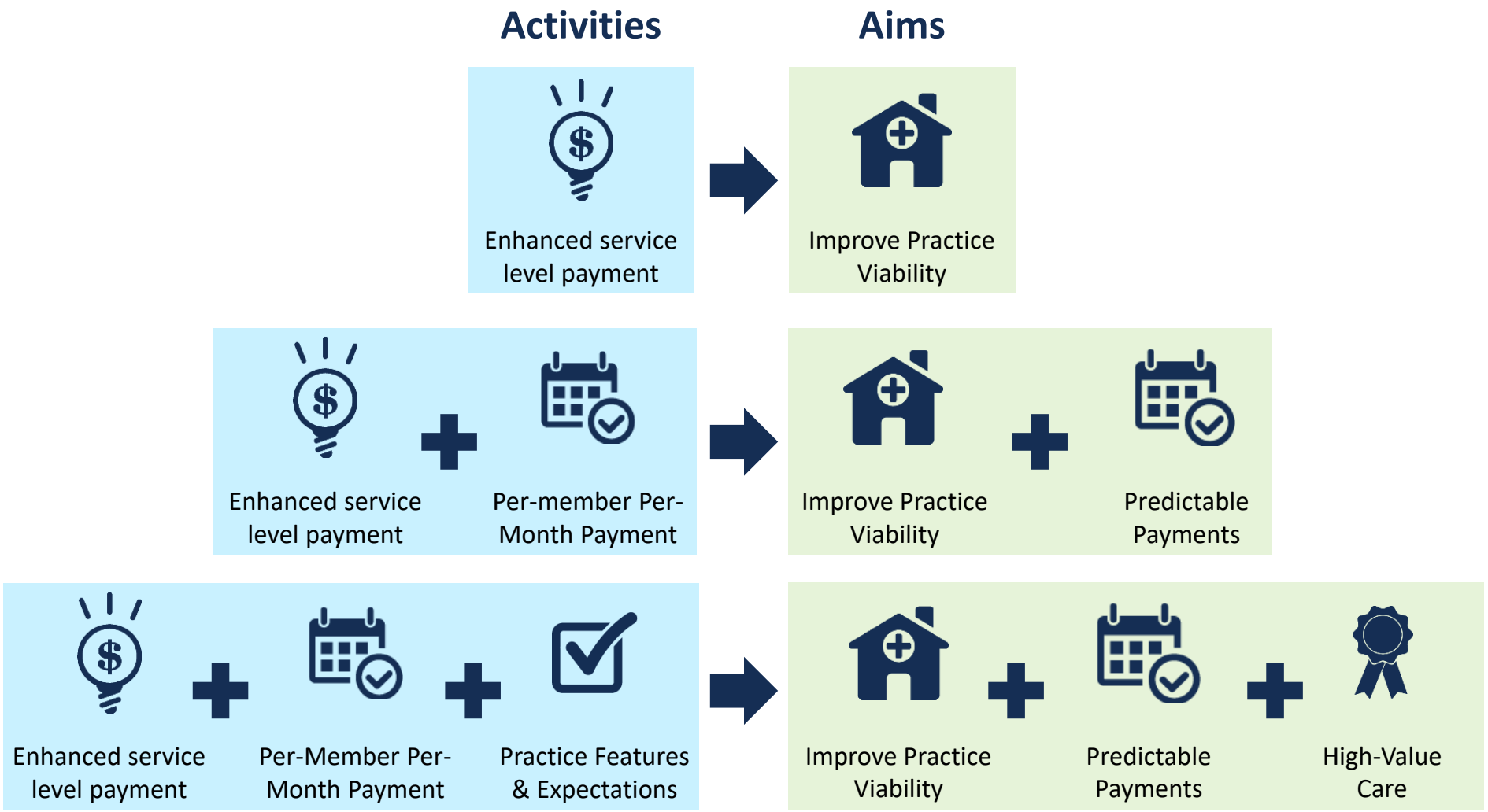
Task Force Aims that Connect to Payment Reform

Improve Practice Viability

Provide Predictable Payment

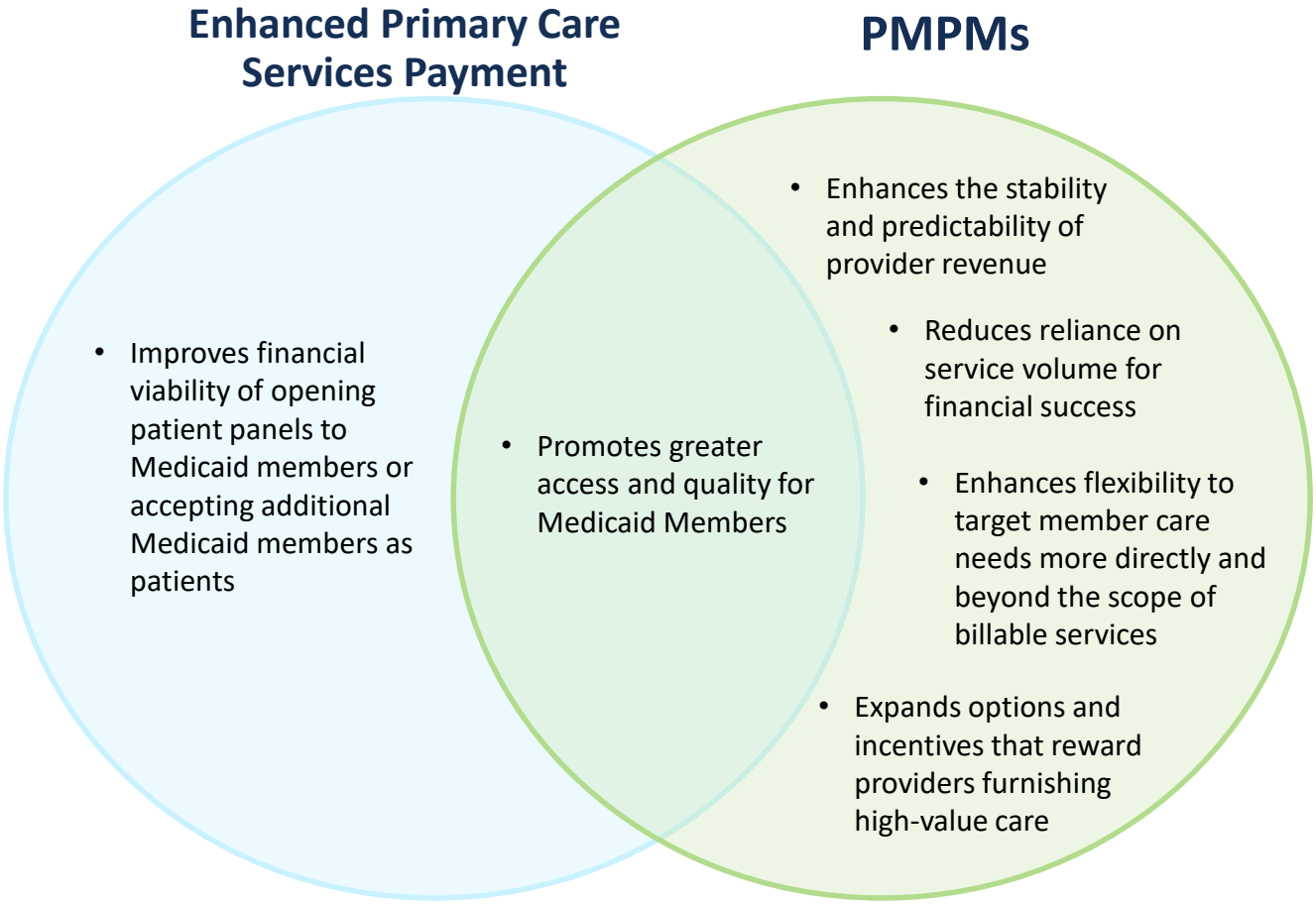
Encourage High Value Care

Achieving Task Force Aims through Payment



Considerations for Achieving the Aims of the Task Force through Payment Reforms

The ultimate goal of these payment reforms in primary care is to improve access to high-quality primary care for Medicaid members and provide the support and flexibility providers require to meaningfully address patient care needs. Enhanced payments and PMPM structures achieve different parts of the aims of this task force.



PAYMENT PARITY WITH MEDICARE

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Assessing the Financial Impact of Medicare Parity

There are two approaches to measure the financial impact of paying at parity with Medicare.

Service Codes

- ✓ Define a range of services codes representing "primary care services", total utilization for those codes, and determine costs using Medicare and Medicaid service level payments.
  - Most common way payment parity is calculated/discussed.
- ✓ Codes may be used by other provider types, which may increase the overall cost; however, the nature of these services is still a primary care focus.

Provider Class

- ✓ Define a provider class based on taxonomy codes, total utilization for those provider classes, and determine costs using Medicare and Medicaid service level payments.
- ✓ More complex analysis and may not capture primary care activities done in non-traditional settings.
- ✓ Provider data in claims often unreliable.

DMAS has traditionally assessed the cost of Medicare payment parity using costs by service code utilization.

Medicare Parity Based on Service Codes

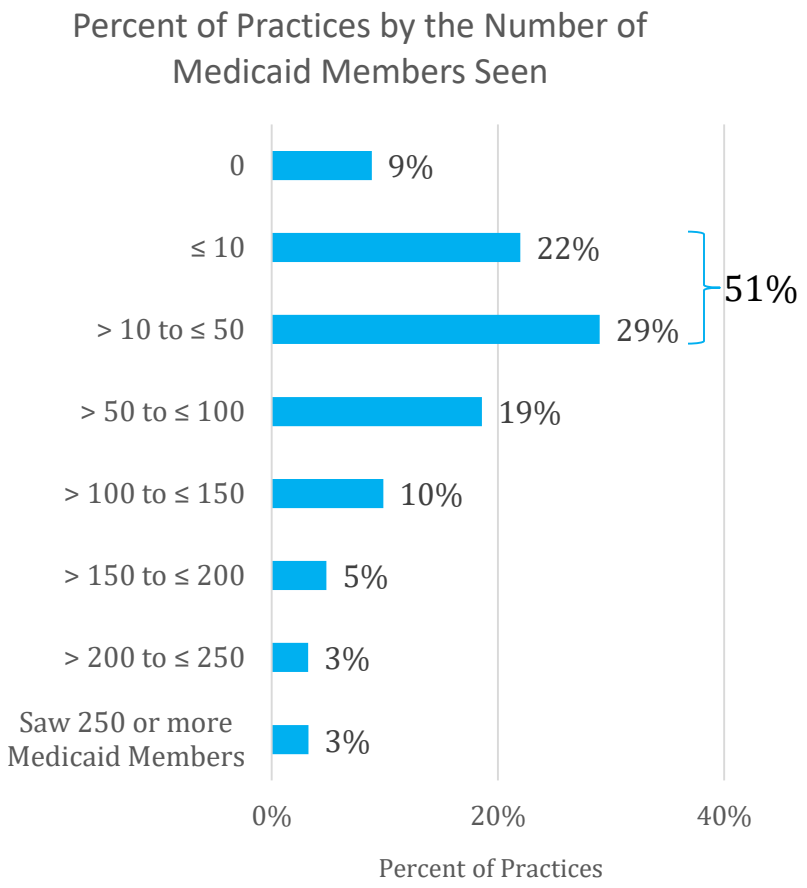
Based on utilization of ~300 primary care related service codes, raising Medicaid rates to parity with Medicare would increase total costs by ~40% or approximately $128M based on SFY 2021 managed care utilization and cost estimates.

Service Category	Total Medicaid Payment, *SFY 2021*	Total Medicare Payment, *SFY 2021*	Difference *(Medicaid-Medicare)*	Percent Increase in Total Medicaid Payment
Adult Preventive and Primary Care	$156,323,383	$226,914,352	$70,590,969	**45%** ↑
Pediatrics	$120,851,208	$163,014,496	$42,163,288	**35%** ↑
Preventive Pediatrics	$35,889,949	$51,259,272	$15,369,323	**42%** ↑
Total	**$313,064,540**	**$441,188,120**	**$128,123,580**	**41%** ↑

Increase Access to Primary Care Services

Increasing the number of Medicaid members PCPs accept in their practice to improve access to services for members.

- ✓ Most PCPs indicated they did not see a large number of Medicaid patients, based on 2016 claims.
  - 3% of practices saw 250+ Medicaid Members
  - 51% of practices saw 50 or fewer Medicaid Members
- ✓ 44% of practices surveyed indicated they offer evening or weekend access.
  - A DMAS review of Medicaid claims showed very low utilization of "enhanced access" CPT codes for services provided during regularly scheduled extended office hours (such as evenings/weekends) or outside of regularly scheduled office hours, or unscheduled services during office hours (such as drop-in or urgent appointments).



Source: Virginia Commonwealth University. Primary Care In Virginia: A Report Conducted On Providers' Perspectives Prior to Medicaid Expansion, Survey of Primary Care Practices and All Payer Claims Data. November 2019. https://hbp.vcu.edu/media/hbp-dev/pdfx27s/policy-briefs/StateofPrimaryCare_ACC.pdf

Limitations of Primary Care Services Payment Parity

Although increasing service level payments in primary care may improve access for Medicaid members and practice viability, it does not move providers away from a volume-driven fee-for-service model and allows less opportunity for incentives to reward high-value care.

- ✓ **Budget Requirements**
- ✓ **Perpetuates Fee-For-Service Model**
- ✓ **Limitations to Rewarding High-Value Care**
- ✓ **Administrative Difficulties Limiting Increase to Primary Care**

PER- MEMBER PER-MONTH (PMPM) PAYMENT MODEL IN PRIMARY CARE

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Structures for PMPMs

PMPM structures can vary, but generally provide predictable payment that offers the flexibility necessary to support a broad range of services, practice features, and member care needs.

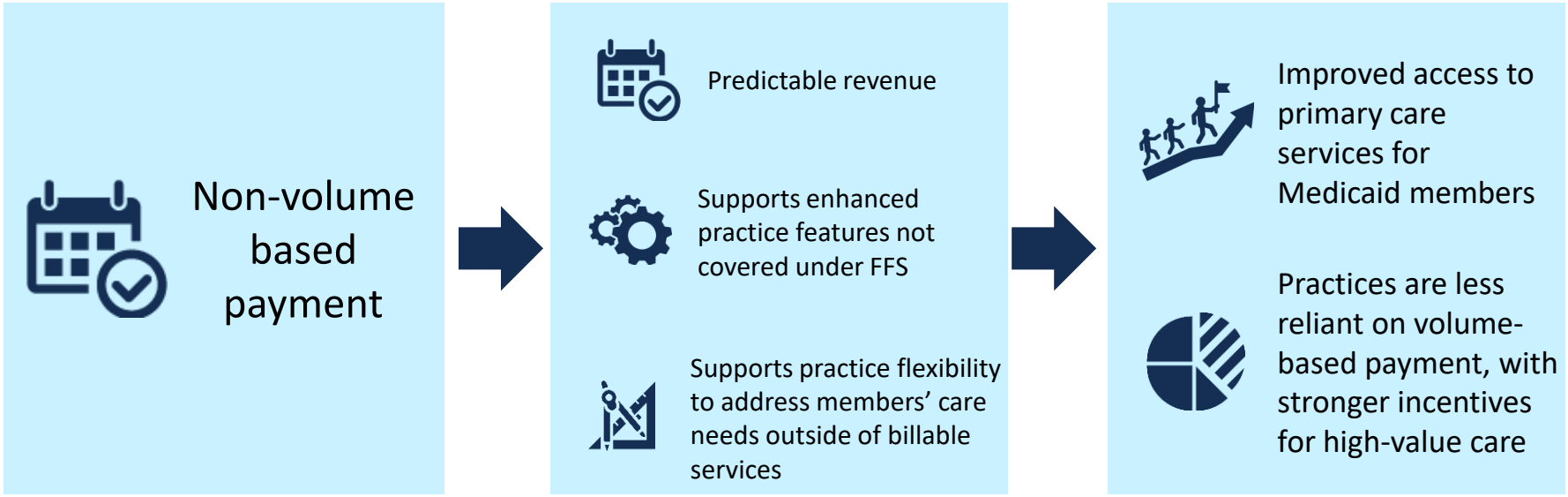
- ✓ CMS issued a **State Medicaid Director Letter** (SMD) on Value-Based Care Opportunities in Medicaid on September 15, 2020. One component of the SMDL outlines PMPM structures and components.
  - Under PMPM models, healthcare providers receive some or all of their payment at some periodic basis upfront, in a lump sum payment.
  - Per-person payments can be risk adjusted to account for the average differences in illness burden across patient panels.
  - Panels can be determined through assignment (prospectively) or through attribution (retrospectively).
  - Some payers have also begun using up-front payment for certain primary care services associated with care delivered to a specific and attributed population.

Source: CMS. SMD #20-004 RE: Value-Based Care Opportunities in Medicaid. September 15, 2020. https://www.medicaid.gov/federal-policy-guidance/downloads/smd-12-002.pdf

Advantages of PMPM Payment for Primary Care

A PMPM model is an opportunity to provide predictable payments, supports flexibility for providers to meet the needs of their patients.

- ✓ PMPM provides predictable payments to practices; addressing top concerns from the VCU primary care survey.
- ✓ PMPM structure is flexible; the parameters and size can be adjusted to fit the goals of the program and the abilities of practices.



Limitations of PMPM in Primary Care

A PMPM creates a new payment structure in Medicaid that, although complex, can address practice viability and predictable payments to PCPs.

- ✓ **More Sophisticated Models Bring Known Complexities**
- ✓ **PMPMs are Not a Guarantee of Quality**
- ✓ **Trade Offs with Member Assignment/Attribution**
- ✓ **Ensuring PMPMs Support Primary Care Environment**

APPROACHES TO ACHIEVE HIGH VALUE CARE WITH PMPM

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Defining High-Value Care

Rewarding high-value care "recognizes the extra work providers do to connect the dots" to improve patient experience, outcomes, and care.

 **Quality**	Prioritizing practice features and expectations that reward providers for improved member experience, outcomes, and care.
 **Population Health**	Aligning practice features and expectations to support broader population health goals to improve the health of members and of the Commonwealth.
 **Sustainable Costs**	Investing in practice features and quality of care that improve short- and long-term health outcomes of individuals, families, and communities.

Paying for Value with Parity

Any enhanced payments to PCPs on the level of parity with Medicare should include policy and expectations for the provision of high-quality care that contributes to better health outcomes for members.

- ✓ **Shift to value from volume**
- ✓ **Reward for performance**

Translating Value into Practice

Potential practice features and markers of high-value care.

Enhanced Practice Features

- ✓ **Extended Access:**
  - Available outside of business hours
  - Same day access to a provider via telephone for urgent needs
- ✓ **Data-driven practice:**
  - Emergency Department Care Coordination Tool
- ✓ **Quality-Centered programs:**
  - Accountable care organizations (ACOs)
  - Patient-centered medical homes(PCMHs)
- ✓ **Practice Transformation**
  - Commitment and measurable progress toward improving systems of care

Markers of High-Value Care

- ✓ **ED utilization**
- ✓ **Patient Experience**
- ✓ **Cancer Screening and Routine Health Maintenance**
- ✓ **Chronic Disease Management**

Flexibility of PMPMs to Support High-Value Care

More advanced payment models allow for the flexibility to include practices at various stages of practice transformation and reward ongoing performance and improvement.

- ✓ PMPMs can be connected to practices' progress towards high-value care.
  - Oregon Medicaid's Patient Centered Primary Care Homes (PCPCH) reward practices with larger PMPMs based on their ranking across five tiers. The PCPCH program directs PMPM payments to each recognized PCPCH based on the associated tier.
  - The PCPCH sets minimum standards for the first tier. PCPCHs can achieve tier 2, 3, and 4 through a mix of practice features and performance expectations. Tier five--also called 5 STAR--requires all must pass criteria, meet or exceed 11 out of 13 performance measures, and a verified site visit.

Illustrative example to show how the size of a PMPM can relate to the level of high-value care delivered by a practice.

Sources:

Oregon Health Authority. Aligning Payment with Quality: Coordinated Care Organizations. July 21, 2019. https://www.oregon.gov/oha/HPA/dsi-pcpch/Pages/Payment-Incentives.aspx

Oregon Health Authority. Patient-Centered Primary Care Home Program: 2017 Recognition Criteria and Technical Specifications and Reporting Guide. September 2018. https://www.oregon.gov/oha/HPA/dsi-pcpch/Documents/TA-Guide.pdf

If we are prepared to invest in primary care, we should invest in high-value primary care.

> "Comprehensive payment models are among the **most innovative and effective** ways to align incentives across payers and providers."

> "These models generally include comprehensive population-based payments…often in the form of … PMPM payment and **being responsible for some or all aspects of a member's care** via a TCOC arrangement."

> "Value-based care may help ensure that our healthcare system is better prepared and equipped to handle similarly disruptive events [like COVID19] in the future."

Source: CMS. SMD #20-004 RE: Value-Based Care Opportunities in Medicaid. September 15, 2020. https://www.medicaid.gov/federal-policy-guidance/downloads/smd-12-002.pdf

Preliminary Primary Care Practice Analysis
April 2022

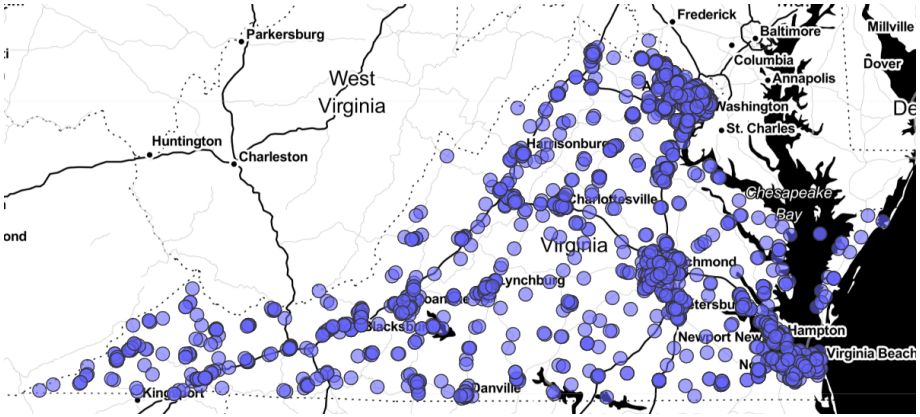
Alex Krist – alexander.krist@vcuhealth.org

VCU Family Medicine and Population Health

ACORN Virginia Ambulatory Care Outcomes Research Network

Surveyed Every Primary Care Practice in VA

2632 Practices in Virginia



https://lavalleema-webaps.shinyapps.io/practiceMapDashboard/

2018 response rate

- 481 of 1622 practices (30% response)

2022 response rate

- 405 of 2632 practices (15% response)
- Interim analysis on 237

- Will close survey May 1

… help us increase our responses!

VCU Family Medicine and Population Health

ACORN Virginia Ambulatory Care Outcomes Research Network

Survey Content

- Practice characteristics
- Medicaid expansion implementation
- Practice operations
- Alternative payment state and interest
- Challenges and opportunities

Primary Care Practice Demographics (n=274)

Practice ownership
- 55% clinician
- 33% health system
- 8% private sponsor
- 3% university / government

Payer mix
- 44% commercial
- 28% Medicare
- 19% Medicaid
- 10% uninsured

Accepting new patients
- 89% commercial
- 79% Medicare
- 69% Medicaid
- 81% uninsured

Practice stresses
- 68% lost a doctor, NP, or PA
- 25% change EMR
- 24% office renovation
- 16% changed billing system
- 13% changed ownership

Scope of Primary Care (n=274)

65% promote generic prescriptions

63% care management for chronic conditions

60% alerts and reminders in EMR

60% measure quality and performance

51% follow up within 24 hours of ER visit or hospitalization

50% provide care coordination or patient navigation

39% follow-up with patients after they see a specialist

30% have strategies to reduce unnecessary medical care

19% have a patient advice line

Provision of Social Care (n=274)

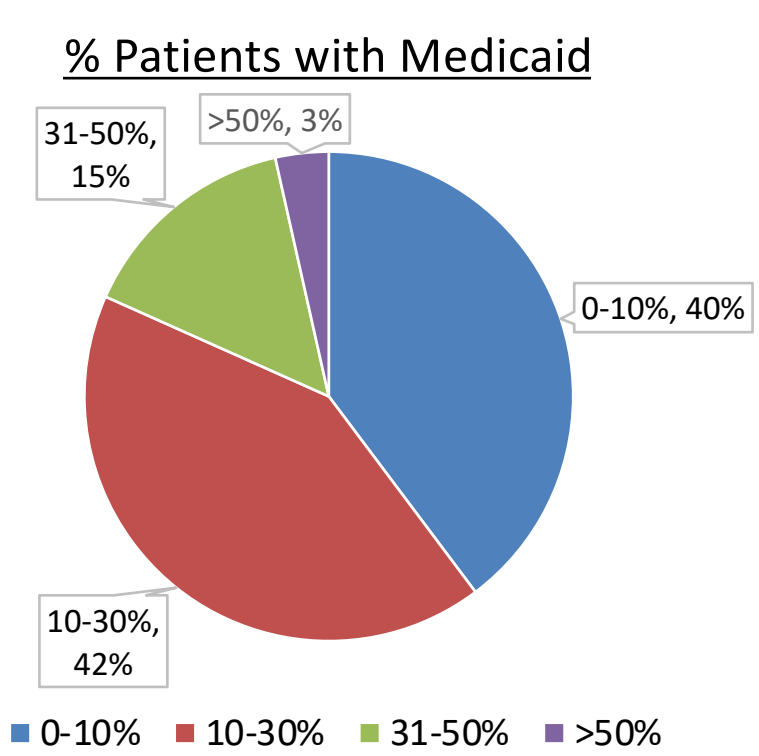
Care for vulnerable populations

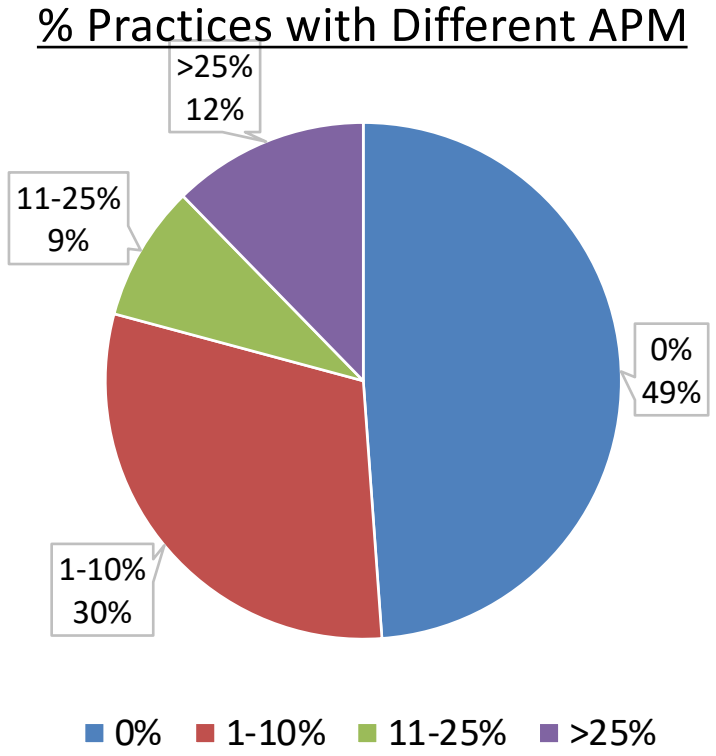
- 77% low income
- 43% group home
- 23% undocumented
- 18% refugee
- 43% transgender
- 31% homeless
- 58% non-English speaking
- 43% opioid use
- 16% none of above

Social care

- 32% routine screening
- 19% have a social worker
- 14% coordinate transportation
- 20% refer to food pantry
- 17% refer to housing resources
- 35% do not have capacity to address social needs
- 45% difficulty referring people for care

Medicaid and Alternative Payment





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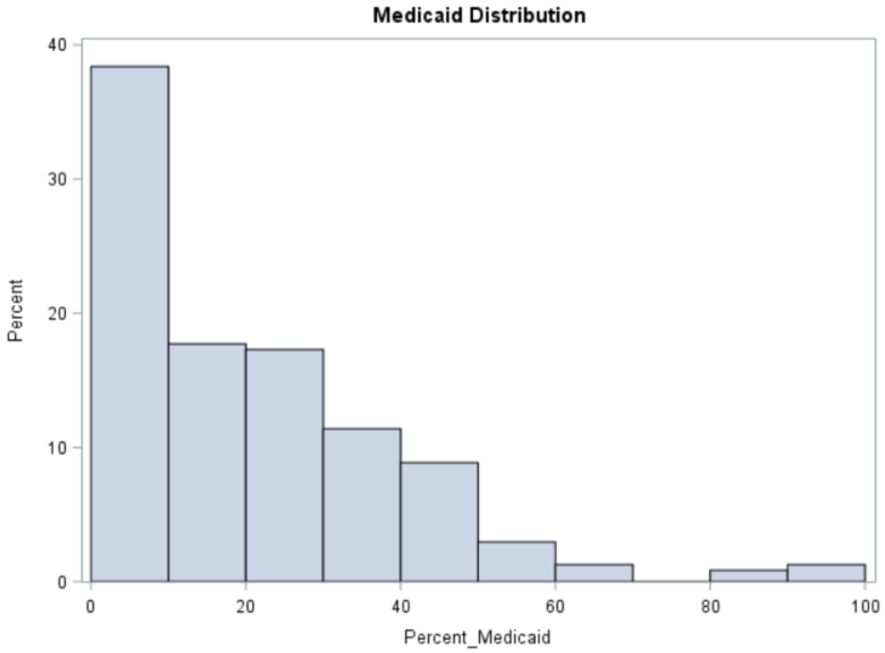
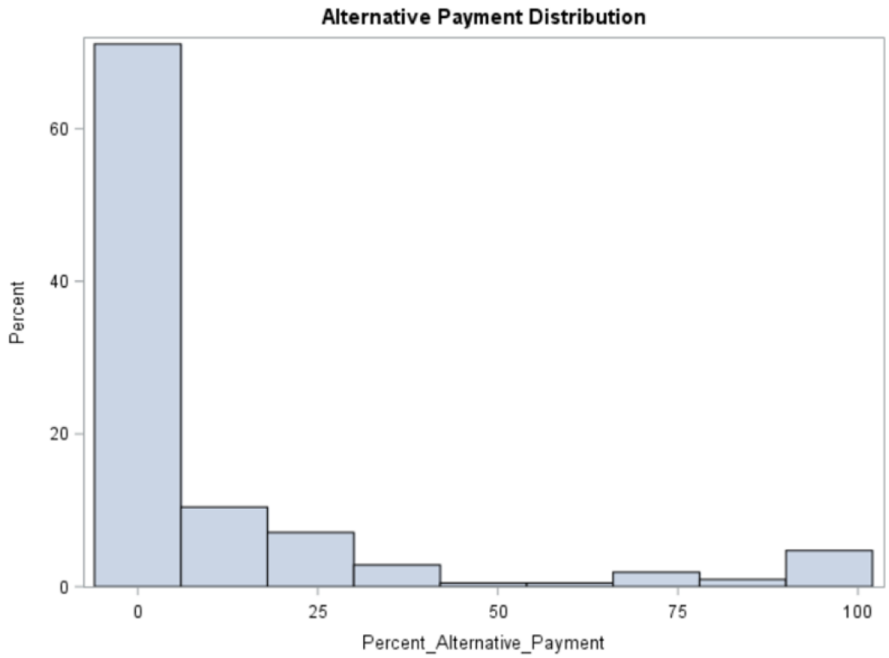
Distribution of Medicaid and Alternative Payment





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ACORN Virginia Ambulatory Care Outcomes Research Network

Low vs High Medicaid Practices (n=274)

Metrics	No / Low Medicaid (<10%)	High Medicaid (>30%)
Care for no vulnerable populations	31%	2%
Saw more patients with Medicaid expansion	36%	86%
Doing better financially with Medicaid expansion	3%	24%
Easier to refer to specialists with Medicaid expansion	7%	21%
Easier to get medications with Medicaid expansion	7%	53%
Hired more clinicians as a result of Medicaid expansion	0%	12%
Hired more staff as a result of Medicaid expansion	3%	12%
Clinician owned	61%	40%
No alternative payments	60%	44%
Average percent of revenue is an alternative payment	11%	5%
Interested in Medicaid alternative payment	12%	63%

Changes Needed to See More Medicaid (n=274)

Metrics	No / Low Medicaid (<10%)	High Medicaid (>30%)
Access to local social worker	49%	39%
Access to local community health worker	57%	39%
Access to local nutritionist	27%	37%
Better access to mental health providers	70%	83%
Better access to specialists	78%	67%

Low vs High Alternative Payment (n=274)

Metrics	No APM (0%)	Middle APM (11-24%)	High APM (>25%)
Care for no vulnerable populations	19%	11%	15%
Saw more patients with Medicaid expansion	57%	72%	57%
Doing better financially with Medicaid expansion	4%	11%	4%
Hired more clinicians as a result of Medicaid expansion	9%	6%	4%
Clinician owned	60%	39%	46%
Would participate in Medicaid APM	29%	65%	28%
APM would not result in any improvements	53%	23%	54%
APM would improve access to care	35%	59%	31%
APM would ensure patients get recommended care	29%	53%	31%
APM would reduce negative care events	31%	47%	35%

Medicaid Reimbursement Is Inadequate

- Medicaid reimbursement needs to be raised to attract more practices
  - "Our lowest payer is Medicare. And so I benchmark our payments on Medicare payments, and I'm looking for commercial payers to pay us you know, 120 to 130% of Medicare so if Medicaid is paying us 63 or 65% of Medicare, obviously that would have to be a much a really big chunk to get us up to 120% of Medicare."
  - "Alternative payment models would probably work for Medicaid, except that the budget in general would have to be bigger in order to pull that off."
- Reimbursement for telephone visits during COVID helped keep some practices financially afloat

Alternative Payment Model – Positives

- Alternative payments could help primary care see more Medicaid members
  - "Over 54% of Medicaid patients have some coexisting mental illness and many of them have a history o active substance abuse, and many of them have very little family or social support. So they need that outreach worker support and they need the case manager and social work support. So value based models would help fund that in our clinic."
- Medicare's Primary Care First may be a good model for capitated payment
  - "One thing that was helpful as we look back at this past year, we actually made more money on our Medicare patients that were attributed to primary care first, just because we got a monthly payment and that also helps to fund some of the salaries of our team members."
  - "Because the medical social workers were billing for their services, and we're taking advantage of some of the billing that our case managers can do, at least for Medicare patients, for chronic disease management, it makes it a financially feasible model."

Alternative Payment Model – Positives

- Alternative payments used to enhance care
  - "With the quality and shared savings contracts, we generally receive care coordination fees, which is a flat payment per member per month. And that payment allows us to pay for some extra staff, a little bit of extra nursing for the providers, so that those nurses have time to communicate with patients more frequently."
  - "If I had a premium paid to me monthly, and it was significant, I could hire a social worker and a nurse to go visit their homes to keep down their costs and keep them healthier."

Alternative Payment Model – Negatives

- Practices worry quality payments may hurt them
  - "They will never take a statin unless you can find a way that it was statin makes you lose weight and maybe makes you prettier and have more energy."
  - "We have a huge non vaccinating community. That's a lot of time for education. Does Medicaid allow for that? I just spent an hour educating someone on a tetanus shot. Maybe they're gonna pay 20 bucks for that. So how does that work out as far as supporting practice and employees and paying rent? I make house calls. Does it account for that?"
- Quality payments seem arbitrary and more like a game to be played
  - "It's a question of clicking a button. You know, and it is really just a question of, are you compulsive enough that you click all the buttons?"
  - "Trying to decide to pay people extra because they played the game well, recording those things, and pay them less because they didn't do a good job of playing that game and recording those things. That rewards a good recorder. It doesn't reward a good doctor. And I think that's the way most people probably are coming to feel is that the bonus and quality reward system and stuff like that, it's just a game that you're playing."

Alternative Payment Model – Negatives

- Concern with how this works for multiple providers
  - "But when you actually put [value based payments] into practice, what you find is that, I take care of this diabetic, but they don't see me for diabetes, they see somebody in another system, and I don't have any records on that. So I don't know how their sugar is doing because they're seeing an endocrinologist, and so I have to then, call the endocrinologist… It's enough to drive you crazy."
- Value based payments may discourage doctors from seeing complex patients
  - "That is the problem with primary care is that whatever you're taking care of right now is what you're writing down… If you go to a capitated system, invariably what will happen is everybody will choose to see the least sick people because they get paid just as much for seeing the least sick people as they get paid for seeing the very sick people. "
  - "The problem with value based care is if doctors are paid based on that kind of metric, then they're going to start dismissing patients that don't meet that metric. Because ultimately we all have to stay in business."

Want to be Paid for the Work They Really Do

- Expand reimbursable activities, including telephone/telehealth visits, messaging, care coordination, case management etc.
  - "I really think that people should be paid for what they do. That's the fee for service model. But we ought to be paid for everything needed. Whether the patient is on the screen or in the office. Not just that point of care."
  - "For our practice, when we're already sold out, if you will, and don't have time to see somebody, I would much rather get paid to make a phone call for five minutes or manage their care, you know, all of the needs that they have, without bringing them into the office. So in my mind, I consider having a monthly payment would actually benefit us in serious ways."
  - "We're doing everything except for actually funding the primary care work. I spent an hour and a half with a methamphetamine addict yesterday. He left his uncompleted Medicaid application in the office so I'm pretty sure he doesn't have any health insurance. Does the system acknowledge that maybe that person will get into treatment and stop using drugs? We'll certainly pay for it when it's a crisis and we admit him to the hospital."

The Healthcare Financing System Is Broken

- [Interviewer: How, how would you like to have the good doctoring reimbursed or the good doctoring acknowledged, financially or through quality measures; what would that look like?] "You know what? I don't have a clue. I have thought about this for years. And, you know, in my own mind, I think that what we should have is a single payer."
- "Well I love the idea of national health care but oh no, there's so many people that are making a profit of this system that I don't know that we're going to let go of it. Like, have we ever really gotten affordable drug prices? Too many people are profiting off of the high prices. That's how our legislature works. They're sponsored by large corporations."

Stress and Burnout Are at Crisis Levels

– "I worry most about the providers. You can really see a difference in their daily demeanor. They're stressed. They're, you know, they're a little more downtrodden than they used to be. And they're wondering what's coming next, with the next COVID surge and how we're going to handle that. And they're frustrated with some of this payment change that can occur, very frustrated with what happened with our commercial contract where they felt like we saved millions of dollars, but we didn't really get paid for that. They're concerned about the future payment models and how they're going to function in that. And so, I think there's a big risk out there for primary care; it's not a real satisfying profession these days."

VIRGINIA TASK FORCE ON PRIMARY CARE

October 2022

Overview

- In July 2020, **VCHI established a Primary Care Taskforce** with the following goals:
  1. Ensure primary care maintains its proven salutary effects - higher quality care at lower costs with greater equity across populations
  2. Better understand trends in primary care and total cost of care
  3. Identify feasible policy solutions to improve appropriate use of primary care
- In **partnership with Milliman MedInsight and Virginia Health Information (VHI)**, prepared numerous reports and analyses to inform state decision-making

VIRGINIA TASK FORCE ON PRIMARY CARE

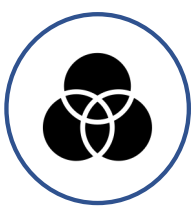
Aims

Coalition

Build a stakeholder coalition

Payment Model

Define a payment model to support primary care and practice viability



Infrastructure

Identify infrastructure and resource needs to support primary care

Quality Measures

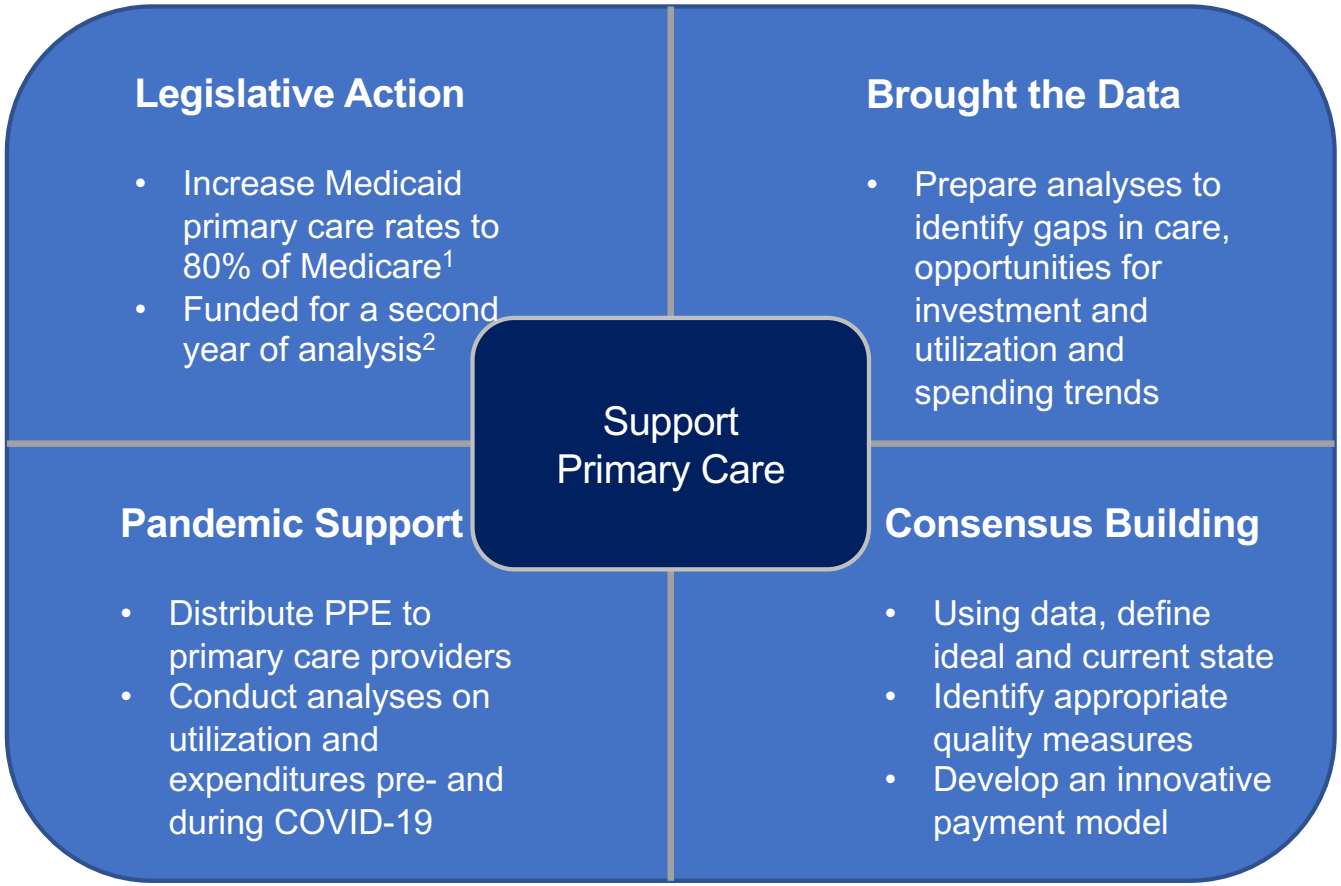
Identify indicators of high value care and appropriate quality measures to evaluate primary care

Innovation

Promote innovation in care delivery

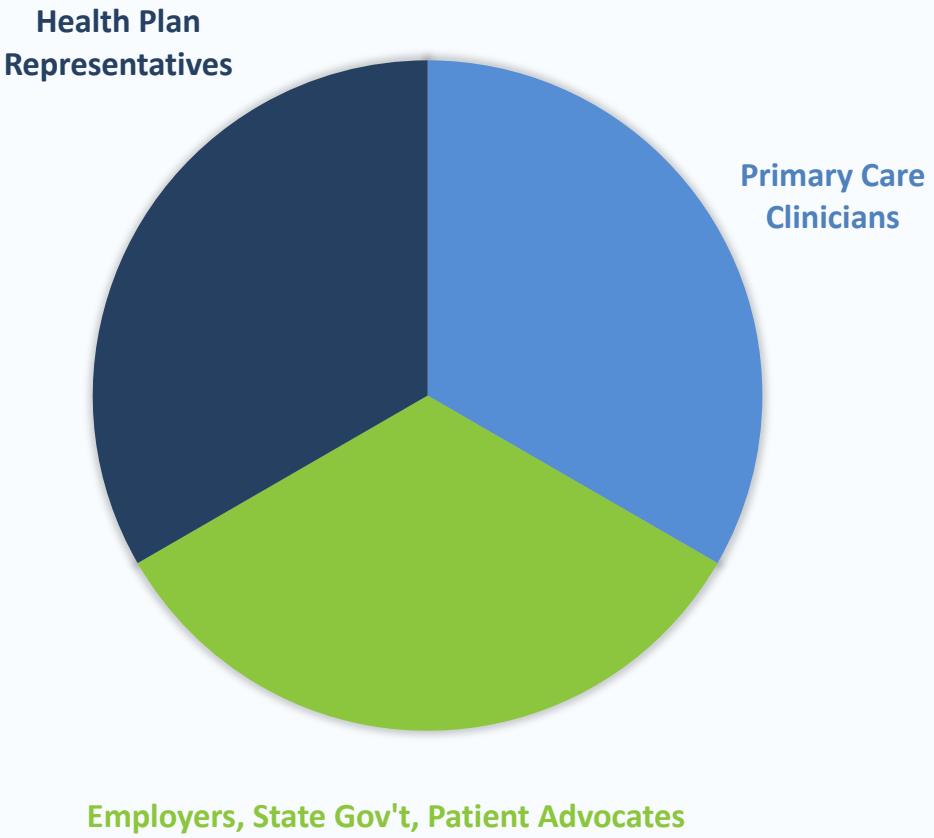
VIRGINIA TASK FORCE ON PRIMARY CARE

Key Accomplishments



VIRGINIA TASK FORCE ON PRIMARY CARE

Task Force Composition



VIRGINIA TASK FORCE ON PRIMARY CARE

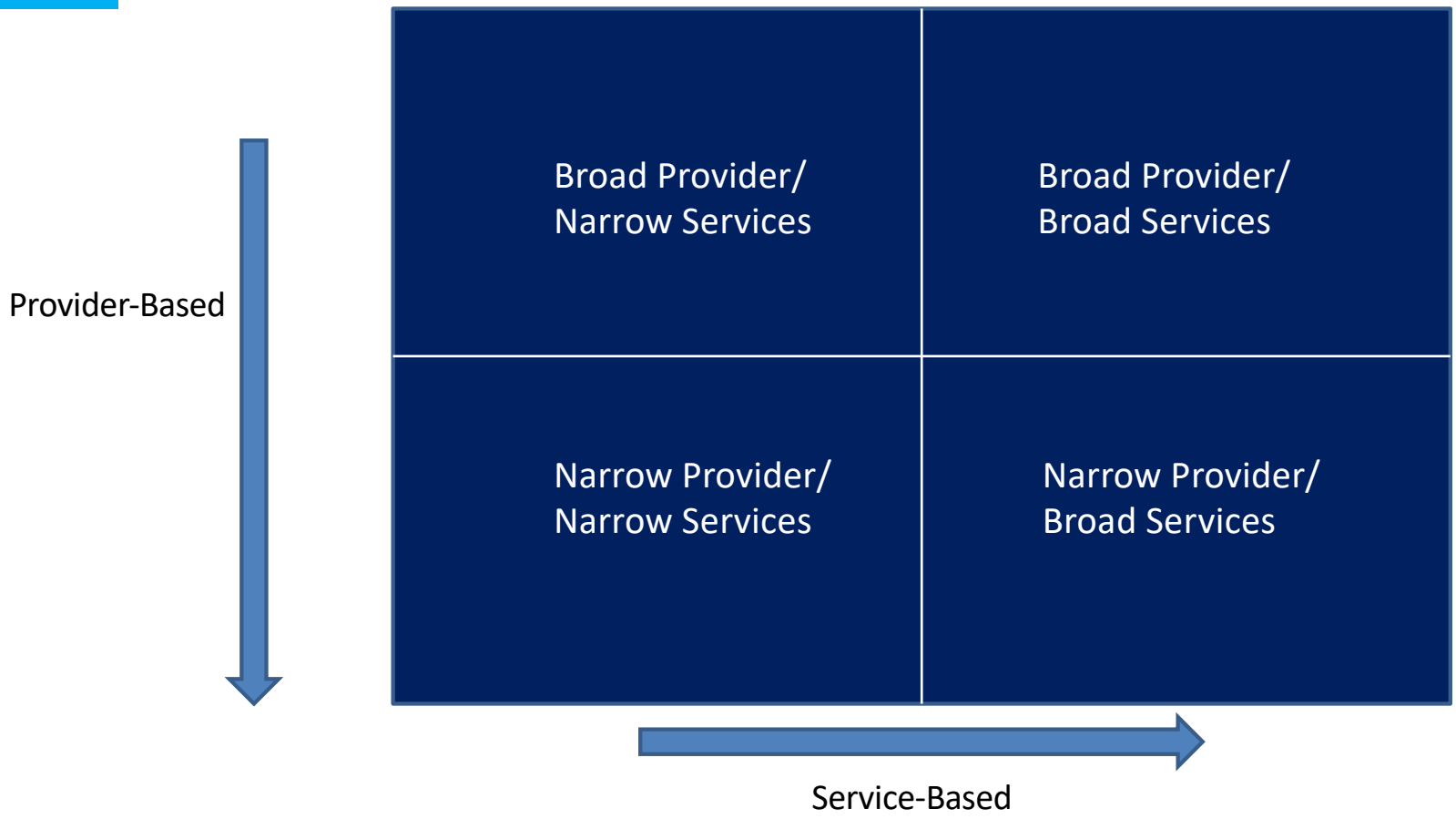
Primary Care Spend Report

Background

- Virginia developed a **four quadrant approach** to defining primary care. Both providers and services were given narrow and broad definitions.
- We utilized APCD data from 2018-2020 and engaged **Milliman MedInsight** to conduct the analysis.
- In order to identify steady state, most analysis relied on **2019** data (pre-COVID-19). However, analyses on utilization during the pandemic also informed taskforce proposals.

VIRGINIA TASK FORCE ON PRIMARY CARE

Defining Primary Care



VIRGINIA TASK FORCE ON PRIMARY CARE

Primary Care Spend as a Percentage of Total Care

- Virginia **all payer spend is below the US average** of 5-7% of health care spend attributable to primary care
- OECD countries spend significantly more proportionately for primary care, with 14% of health care dollars spent on primary care
- **Medicaid spends a significantly smaller proportion** of its health care expenditures on primary care compared to other payers

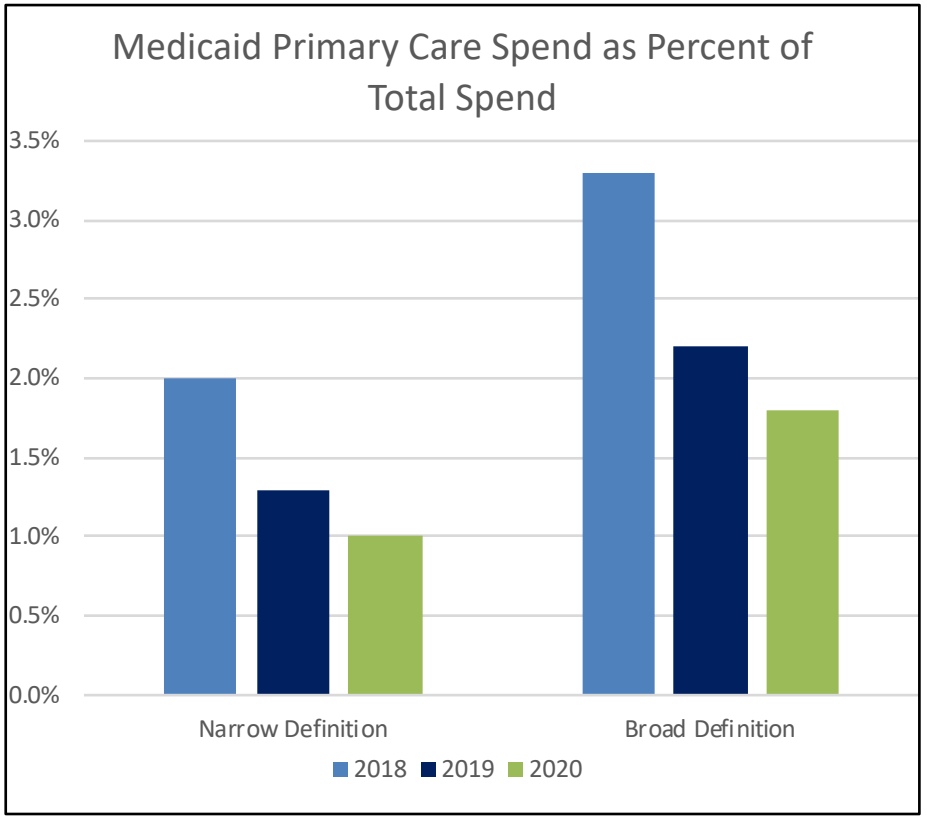
	Narrow Provider/ Narrow Service (minimum)	Broad Provider/ Broad Service (maximum)
Medicaid	1.3%	2.2%
Medicare	2.7%	4.5%
Commercial	3.7%	6.0%
All Payers*	**2.4%**	**4.0%**

**Reflects payer mix of APCD which is more heavily weighted towards Medicaid and Medicare payers than Virginia's population overall*

VIRGINIA TASK FORCE ON PRIMARY CARE

Medicaid Primary Care Spend

- Over the last 3 years of available data, **primary care spend has been decreasing** as a percentage of total spend in Medicaid.
  - This trend is consistent regardless of the definition of primary care
  - This trend began before the COVID-19 pandemic.
  - In 2019, Virginia expanded Medicaid, with more individuals now receiving their primary care through Medicaid



VIRGINIA TASK FORCE ON PRIMARY CARE

Role of Primary Care Differs by Payer

- As a result of eligibility requirements for Medicare and Medicaid, most common conditions treated by primary care differ by payer
- However, for all payers, primary care plays a significant role in treating mental health conditions

Top 5 Conditions with Highest Spend In Primary Care
(% of Total Primary Care Spend)

Commercial	Medicare	Medicaid
1. Hypertension (9%)	1. Hypertension (15%)	1. Mental Health (10%)
2. Diabetes (6%)	2. Mental Health (13%)	2. Intellectual disability (9%)
3. Mental Health (5%)	3. Diabetes (10%)	3. Asthma (8%)
4. Asthma (5%)	4. Cancer (10%)	4. Unhealthy newborn (5%)
5. Cancer (4%)	5. Kidney failure (10%)	5. Hypertension (5%)

VIRGINIA TASK FORCE ON PRIMARY CARE

Primary Care Settings

- Even using the broadest definition of primary care providers, nearly half (45%) of primary care services are provided by **non-primary care providers** (i.e., specialists), which are often more costly

- **Urgent Care** accounts for 4% of all primary care expenditures, using the broadest definition
  - Medicare beneficiaries are lease likely to use urgent care (3%)
  - Medicaid beneficiaries are most likely to use urgent care (9%)

- **Telehealth** expenditures as a percentage of total primary care expenditures increased drastically in 2020 with the COVID-19 pandemic
  - In 2018, telehealth expenditures accounted for less than 0.5%, and increased to 10.5% in 2020

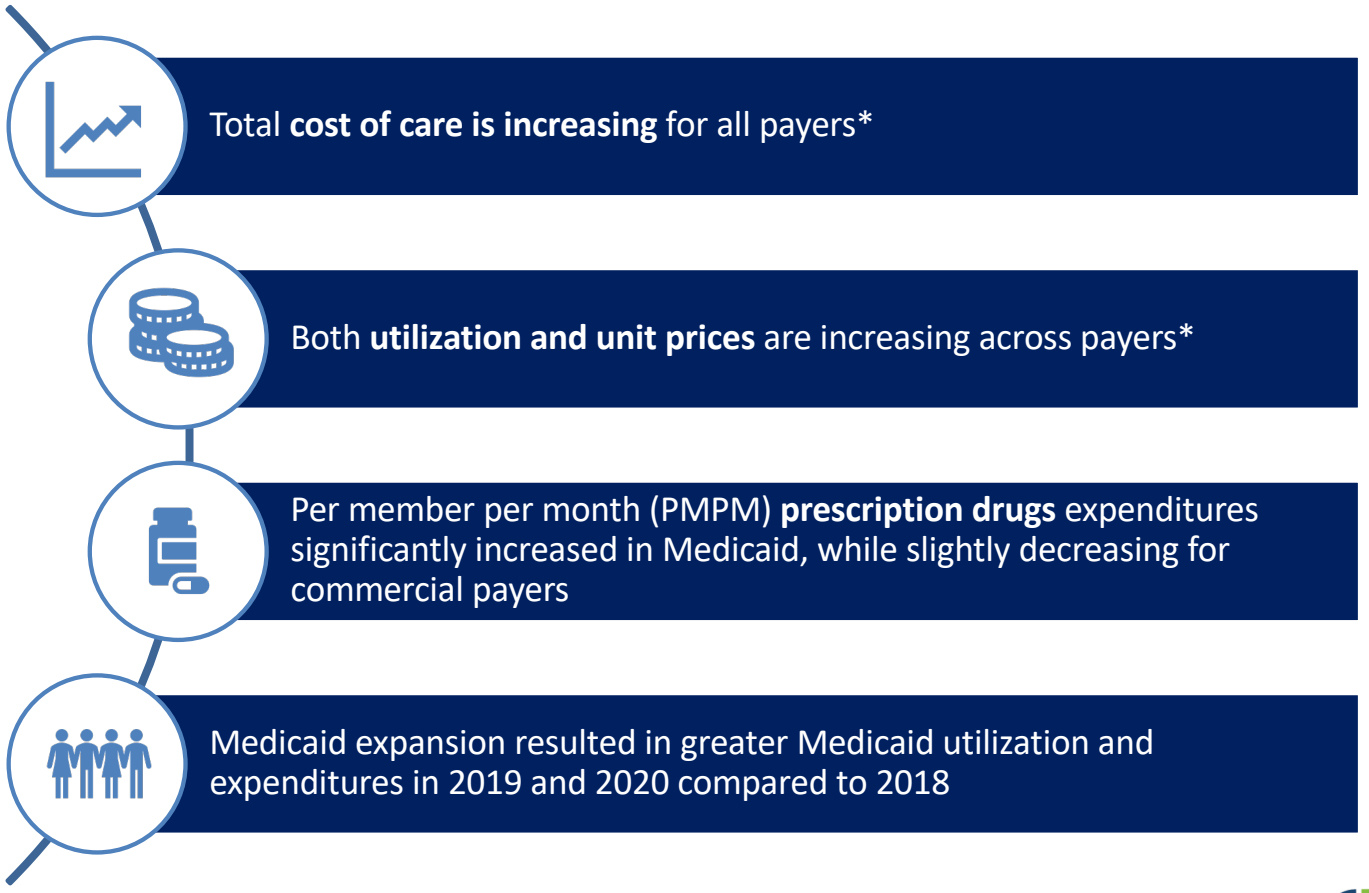
VIRGINIA TASK FORCE ON PRIMARY CARE

Total Cost of Care Report

Background

- Provides a deep dive into the cost and cost drivers of health care in Virginia.
- Specifically, it looks at cost drivers of major services and of chronic conditions, and segregates the analysis by insurance type and by health planning region.
- Increases in per member per month (PMPM) spending can be attributed to increases in resource use or increases in unit prices.

Total Cost of Care on the Rise



VIRGINIA TASK FORCE ON PRIMARY CARE

** Medicare FFS data does not include pharmaceutical data and therefore overall increase cannot be determined*

Key Drivers of Total Cost of Care

Commercial

- Outpatient services (i.e. facility component of office-based visits/procedures)
- Professional services (e.g. physician visits, inpatient procedures, radiology, pathology, and other services)
- High cost imaging
- Office-administered medications

Medicare

- Office-administered medications
- Inpatient services

Note – prescription data unavailable for Medicare FFS

Medicaid

- Inpatient services
- Prescription drugs (4 of top 5 drivers)

VIRGINIA TASK FORCE ON PRIMARY CARE

High Cost Chronic Conditions

- Individuals with certain conditions drive the costs for each payer
- Cancer, Hypertension, and Kidney Failure are drivers across all payers

Top 5 Conditions with Highest Spend
(% of Total Spend by Payer)

Commercial	Medicare Advantage*	Medicaid
1. Cancer (14%)	1. Cancer (17%)	1. Kidney Failure (10%)
2. Hypertension (10%)	2. Kidney Failure (14%)	2. Severe Dementia (10%)
3. Diabetes without Coronary Artery Disease (9%)	3. Hypertension (10%)	3. Cancer (8%)
4. Kidney Failure (9%)	4. Diabetes without Coronary Artery Disease (9%)	4. Hypertension (7%)
5. Healthy Female (7%)	5. Severe Heart Disease (includes transplant) (7%)	5. Major Psychosis (7%)

*Note – Medicare FFS is excluded because prescription data was unavailable

VIRGINIA TASK FORCE ON PRIMARY CARE

Legislative Action

Key Activities

- As a result of the work from the Virginia Task Force on Primary Care, the General Assembly appropriated **$81.9 million to increase primary care rates** in state fiscal years 2023 and 2024
- Rate for Medicaid primary care services are being increased to **80% of Medicare**, a substantial increase for many primary care services
- The Task Force has been **funded for another 2 years**, with additional reports and briefs planned

VIRGINIA TASK FORCE ON PRIMARY CARE

What's Next

- Provide baseline and trend information on primary care to the General Assembly
- Expand Primary Care and Total Cost of Care reports to take a deeper dive into drivers, settings, trends, and impact of COVID-19
- Pilot a Virginia Primary Care Scorecard
- Pilot new primary care performance measures and evaluate their potential for national implementation
- Launch a Virginia Clinician Retention and Well-Being Collaborative
- Launch the Virginia Primary Care Innovation Hub
- Assist Virginia Medicaid with payment reform model design and building data infrastructure to support necessary analytics

Center for Connected Health Policy

THE NATIONAL TELEHEALTH POLICY RESOURCE CENTER

Telehealth Policies and Federally Qualified Health Centers

FQHC FACT SHEET

Fall 2022

With support from the National Association of Community Health Centers (NACHC) through funding from the Health Resources and Services Administration (HRSA), the Fall 2022 Edition of the Center for Connected Health Policy's (CCHP) Telehealth summary report and Policy Finder tool have a new category for each state on federally qualified health centers' (FQHCs) telehealth Medicaid fee-for-service policy. As is the case for Medicaid telehealth policy in general, the manner in which state Medicaid programs address telehealth reimbursement for FQHCs, and therefore enable them to incorporate telehealth into their clinics, varies widely by state.

Methodology

- State Medicaid manuals, administrative codes, and manuals for fee-for-service policies were reviewed between July and early September 2022.
- CCHP only counts states as providing reimbursement if official and explicit Medicaid documentation was found confirming they are reimbursing FQHCs specifically for a certain modality. A broad statement that all providers are reimbursed or any originating site is eligible without an explicit reference to FQHCs was insufficient.
- COVID-19 emergency policies are not included in CCHP's reporting. Only permanent policies are accounted for.
- A state Medicaid program was counted as reimbursing FQHCs even if they do so in a very limited way, such as only for mental health.

Key Findings

Definition of Encounter/Visit & Same Day Encounters

The majority of Medicaid programs do provide a definition for a FQHC 'encounter' or 'visit' that stipulates that it is a face-to-face interaction. This does not necessarily preclude use of telehealth, as live video can also be considered 'face-to-face'. In fact, some Medicaid programs do specify in their definition of an encounter/visit that a telehealth would qualify as a visit.

EXAMPLE:

OREGON is a rare example of a state that defines an encounter as face-to-face, which includes a two-way audiovisual link, OR telephone contact under specific circumstances.

CALIFORNIA'S definition of a visit also includes audio-only synchronous interaction as well as asynchronous store-and-forward for certain FQHC providers.

Note that the cases of Oregon and California are rare, and most states limit their definitions to either to live video telehealth or don't explicitly reference telehealth modalities at all.

Telehealth Policies and Federally Qualified Health Centers

CCHP examined each state Medicaid program's policy on 'same day encounters/visits'. Many states have limitations around FQHCs claiming more than one encounter in a single day for a single patient. This is thought to be a limitation applicable to telehealth because it is common for a patient to visit a FQHC for a primary care visit, and upon examination require a specialty service (such as mental health). Connecting to the appropriate provider via telehealth may be feasible the same day but if it's not reimbursed, FQHC staff are unlikely to be able to offer the option to their patients. Through its research, CCHP observed that most state Medicaid programs do indeed have limitations around same day encounters, particularly if the services occur at the same location and are both considered the same type of encounter (for example, a medical encounter). However, there are often allowances for multiple encounters if the service is considered a different type of encounter, for example a mental health encounter.

EXAMPLE:

ARKANSAS MEDICAID allows a family planning visit to occur on the same day as a 'core service encounter.'

Eligible as Originating & Distant Sites

- **Originating sites:** 36 states and DC explicitly allow FQHCs to serve as originating sites for telehealth-delivered services. This information was often found in state Medicaid manuals or regulatory lists of eligible originating sites, where FQHCs were one of the sites listed. If a state does reimburse a facility fee, it is common for FQHCs to be eligible to collect the fee, however not every state Medicaid program reimburses the facility fee.

EXAMPLE:

MAINE policy clarifies that FQHCs can serve as an originating site and be paid separately from the center or clinic all-inclusive rate. They also clarify that FQHCs can serve as distant sites and bill under the encounter rate.

- **Distant sites:** 34 states and DC explicitly allow FQHCs to be distant site providers. This was often stated in Medicaid manuals or regulations as a clarification so that there would be no confusion about their eligibility for reimbursement. In some cases, policy also addressed whether or not they would be eligible for the prospective payment system (PPS) rate.
    - o 20 state Medicaid programs and DC explicitly clarify that FQHCs are eligible for the PPS rate when serving as distant site providers.

Store-and-Forward Reimbursement

The vast majority of states did not specify or excluded store-and-forward from an eligible service FQHCs could be reimbursed for.

- 4 state Medicaid programs explicitly reimburse FQHCs for store-and-forward.

EXAMPLE:

IOWA MEDICAID provides reimbursement for asynchronous teledentistry under certain circumstances, while California generally covers asynchronous services for FQHCs.

FACT SHEET

Telehealth Policies and Federally Qualified Health Centers

Audio-Only Reimbursement

Most states do not specify or exclude audio-only services from being reimbursed for FQHCs. Because most definitions of an encounter require a face-to-face interaction, this can implicitly limit the ability of audio-only services.

- 9 state Medicaid programs explicitly allow reimbursement for audio-only services to FQHCs. In some cases, services are only reimbursed through communication technology-based codes (CTBS), or have other restrictions (such as limitations around the service type) limiting its use.

EXAMPLE:

SOUTH DAKOTA MEDICAID allows FQHCs to be reimbursed for Substance Use Disorder (SUD) agency services provided via audio-only if the provider is an accredited and enrolled agency. Audio-only behavioral health services are reimbursed at the encounter rate. California allows FQHCs to be reimbursed for audio-only at their PPS rate, but only for established patients.

Remote Patient Monitoring Reimbursement

While most states did not address whether or not FQHCs would be eligible for remote patient monitoring, in a few instances CCHP noted states that allowed them to be reimbursed through CTBS codes, although separate from their 'core services' or encounter rate.

EXAMPLE:

NORTH CAROLINA MEDICAID allows FQHCs to be reimbursed for remote patient monitoring on a fee-for-service basis based on a fee schedule and rates established for remote patient monitoring codes.

EXAMPLE:

CALIFORNIA MEDICAID is unique in having limitations around establishing a patient provider relationship via store-and-forward and audio-only modalities that apply to FQHCs only, while other types of California Medicaid providers do not have to adhere to the same rules.

Services Outside the Four Walls

FQHCs have sometimes had to adhere to rules restricting services from being rendered outside of the four walls of their facility. This can pose a problem for telehealth encounters when the patient may be at home and connecting to a FQHC provider. CCHP found that Medicaid policies did not always address this situation explicitly, although many Medicaid policies provided allowances for visiting nurse services in the patient's home. The policies that were found to allow FQHC services to the home often did not address a telehealth situation explicitly leaving it ambiguous whether this model of care is allowed.

EXAMPLE:

NEW MEXICO Medicaid allows FQHC services in an outpatient setting, including a patient's place of residence, but doesn't address whether or not telehealth would be allowed to deliver those services explicitly.

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Telehealth Policies and Federally Qualified Health Centers

KEY

✓ = FQHCs are eligible

✗ = FQHCs are not eligible OR no explicit reference found.

Originating site: FQHC eligible for originating site live video reimbursement

Distant site: FQHC eligible for distant site live video reimbursement

S&F: FQHC eligible for store and forward reimbursement

Audio Only: FQHC eligible for audio only reimbursement

PPS: FQHC eligible for Prospective Payment System (PPS) rate for telehealth services

Medicaid Telehealth Reimbursement for FQHCs

STATE	ORIGINATING SITE	DISTANT SITE	S&F	AUDIO ONLY	PPS
Alaska	✓	✓	✓	✓	✗
Alabama	✓	✗	✗	✗	✗
Arkansas	✓	✗	✗	✗	✗
Arizona	✗	✓	✗	✗	✗
California	✓	✓	✓	✓	✓
Colorado	✓	✓	✗	✓	✓
Connecticut	✓	✓	✗	✗	✓
District of Columbia	✓	✓	✗	✗	✓
Delaware	✓	✗	✗	✗	✗
Florida	✗	✗	✗	✗	✗
Georgia	✓	✓	✗	✗	✗
Hawaii	✓	✓	✗	✗	✓
Iowa	✓	✓	✓	✗	✗
Idaho	✗	✓	✗	✗	✗
Illinois	✓	✓	✗	✗	✓
Indiana	✓	✓	✗	✓	✓
Kansas	✓	✓	✗	✗	✗
Kentucky	✓	✓	✗	✗	✗
Louisiana	✗	✓	✗	✓	✓
Massachusetts	✗	✓	✗	✗	✗
Maryland	✓	✓	✗	✗	✗
Maine	✓	✓	✗	✗	✓
Michigan	✓	✓	✗	✓	✓
Minnesota	✓	✓	✗	✗	✗

Telehealth Policies and Federally Qualified Health Centers

STATE	ORIGINATING SITE	DISTANT SITE	S&F	AUDIO ONLY	PPS
Missouri	✓	✗	✗	✗	✗
Mississippi	✓	✓	✗	✗	✗
Montana	✓	✗	✗	✗	✗
North Carolina	✓	✓	✗	✓	✓
North Dakota	✗	✗	✗	✗	✗
Nebraska	✗	✓	✗	✗	✓
New Hampshire	✓	✗	✗	✗	✗
New Jersey	✓	✓	✗	✗	✗
New Mexico	✓	✗	✗	✗	✗
Nevada	✓	✓	✗	✗	✗
New York	✓	✓	✓	✗	✓
Ohio	✗	✓	✗	✗	✓
Oklahoma	✗	✗	✗	✗	✗
Oregon	✗	✗	✗	✓	✗
Pennsylvania	✗	✓	✗	✗	✓
Puerto Rico	✗	✗	✗	✗	✗
Rhode Island	✗	✗	✗	✗	✗
South Carolina	✓	✓	✗	✗	✓
South Dakota	✓	✓	✗	✓	✓
Tennessee	✓	✗	✗	✗	✗
Texas	✓	✓	✗	✗	✓
Utah	✗	✗	✗	✗	✗
Vermont	✗	✗	✗	✗	✗
Virginia	✓	✓	✗	✗	✗
Virgin Islands	✗	✗	✗	✗	✗
Washington	✓	✓	✗	✗	✓
Wisconsin	✓	✓	✗	✗	✓
West Virginia	✓	✓	✗	✗	✓
Wyoming	✓	✗	✗	✗	✗

A Landscape Analysis of Telehealth Utilization and Impact to the Total Cost of Care

Developed for the Virginia Community Healthcare Association
by Community Health Solutions

Updated October 8, 2021

Introduction

This report presents a landscape analysis of telehealth utilization and impact to the total cost of care. Community Health Solutions (CHS) developed this report for the Virginia Community Healthcare Association in response to RFP #HCCN-2021-01.[1]

In the following sections we describe the study approach, the possibilities for telehealth, the evolving telehealth landscape, strategic considerations for Virginia health centers, and ideas for supporting health centers. These results will also be presented in a webinar to be scheduled in coordination with the Association.

Report Outline

A. The Study Approach

The study approach was crafted to meet the requirements of the RFP, and included a scan of the field and two listening sessions to obtain insight from health center staff. The results inform the findings throughout this report, and will also be presented in a webinar to be scheduled.

Section Outline

RFP Guidance. The intent and purpose of the RFP was to solicit proposals from qualified sources to analyze the healthcare landscape, as it pertains to Federally Qualified Health Centers in Virginia, regarding telehealth utilization specific to COVID-19 impact and to understand the changing cost of care. Additional expected outcomes of this report include, but are not limited to, research to understand the changes in providing clinical care (models, workflow, staffing, equipment, etc.). Based on the results of the research and evaluation, a webinar will be delivered to the health centers on a date to be specified.

Scan of the Field. The scan of the field was focused on developments in telehealth utilization specific to COVID-19 impact, implications for the changing cost of care, and implications for providing care (models, workflow, staffing, equipment, etc.) Sources for the scan included national and state associations, state and federal government agencies, research organizations, accreditation organizations, journal publications, opinion articles by thought leaders, and video presentations on the relevant topics. A list of selected sources is provided in **Appendix A**.

[1] #HCCN-2021-01: Health Center Controlled Network (HCCN) Subject Matter Expert (SME)Telehealth Utilization and Impact Total Cost of Care Landscape Analysis. The contract period is June 7, 2021, through July 12, 2021.

Health Center Insight. CHS facilitated two listening sessions to obtain insights from health center leaders. In these sessions, six leaders from four different health centers shared their insights about the study topics from their local viewpoint. A list of participants and interview questions is provided in **Appendix B**.

B. The Possibilities for Telehealth

The Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) defines **telehealth** as:

> *The use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, and public health and health administration.*

It is worth noting that the terminology for telehealth is evolving. Various terms used to describe telehealth include virtual care, telemedicine, telebehavioral health, teledentistry, telepsychiatry, and more. For this report we assume the term telehealth to encompass any of these alternative words for the concept.

Exhibit 1
Possibilities for Telehealth

Service Focus / Telehealth Mode	Medical Care	Dental Care	Mental Health Care	Vision Care	Pharmacy Care	Substance Use Services	Enabling Services
Patient Facing							
Telephone call (tVisit)	*	*	*	*	*	*	*
Video visit (vVisit)	*	*	*	*	*	*	*
Secure messaging (eVisit)	*	*	*	*	*	*	*
Mobile health applications (mhealth)	*	*	*	*	*	*	*
Remote patient monitoring (RPM)	*	*	*	*	*	*	*
Provider Facing							
Telemetry for emergency services	*	*	*	*	*	*	*
eConsult supports for clinicians	*	*	*	*	*	*	*
Project ECHO supports for clinicians	*	*	*	*	*	*	*
Store and forward technologies	*	*	*	*	*	*	*

As shown in **Exhibit 1**, telehealth may be used to deliver a wide range of patient services including medical care, dental care, mental health care, vision care, pharmacy care, substance use services, and enabling services.[2] These services can be delivered through multiple channels including phone visits, video visits, secure messaging, mobile health applications (including texting), and remote patient monitoring.

[2] **Enabling services** are defined by HRSA to include case management, referrals, translation/interpretation, transportation, eligibility assistance, health education, environmental health risk reduction, health literacy, and outreach.

C. The Evolving Telehealth Landscape

The telehealth landscape shifted dramatically during 2020, and it is shifting again in 2021. This section reviews the telehealth landscape before the pandemic, during the pandemic, and for 2021 and beyond. We also review findings on telehealth and the total cost of care, and the implications of telehealth for clinical operations.

Section Outline

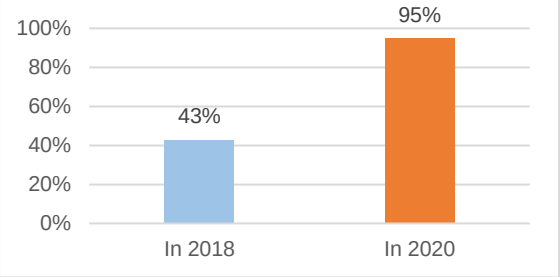
Health Center Trends → Outpatient Service Trends → Dental Care Trends → Mental Health Care Trends → Telehealth and Health Equity → Telehealth and Total Cost of Care → Telehealth in 2021 and Beyond

Health Center Trends

At this point in time there are limited data available to analyze the telehealth trend before and during the pandemic for Virginia health centers. We do know that Virginia health centers were making substantial use of telehealth prior to the pandemic. To illustrate, in 2018 an estimated 50% of Virginia health centers used some form of telehealth, compared to 43% of health centers nationally.[3]

In the absence of robust state data, national trends can provide a helpful reference point for considering what has been happening in Virginia. As illustrated in **Chart A** within **Exhibit 2**, an estimated 43% of health centers nationally used telehealth in 2018. The leading uses in 2018 were for behavioral health, primary care, managing chronic conditions, consumer and professional health education, dermatology, and oral health. Looking at telehealth adoption rates nationally, prior to COVID-19 health centers were adopting telehealth applications at higher rates than other primary care providers, including video-conferencing, store and forward applications, interacting with patients, and consulting with other providers.[3]

Exhibit 2
Telehealth Trend Indicators for Health Centers (National Data)



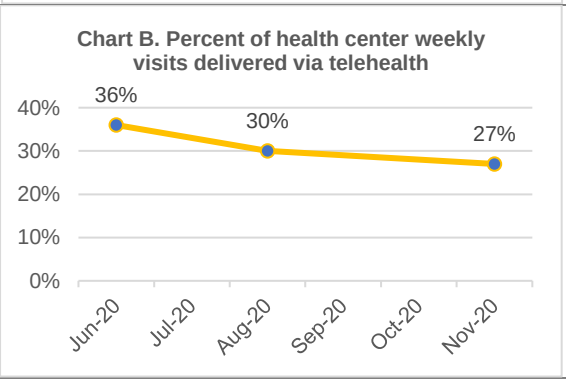


Chart A Source: National Association of Community Health Centers, Community Health Center Chartbook, 2020.

Chart B Source: Demeke HB, Merali S, Marks S, et al. Trends in Use of Telehealth Among Health Centers During the COVID-19 Pandemic — United States, June 26–November 6, 2020. MMWR Morb Mortal Wkly Rep 2021;70:240–244. DOI: http://dx.doi.org/10.15585/mmwr.mm7007a3

[3] National Association of Community Health Centers, Health Center Chartbook, 2020

As also shown in **Chart A**, in 2020 the percent of health centers using telehealth rose dramatically to **95%** of health centers nationally.[3] As shown in **Chart B**, a separate analysis of a national sample of health centers indicates that in June of 2020, 36% of weekly health center visits were delivered via telehealth, with rates as high as 48% in the Northeast and as low as 20% in the South. There was also a significant difference between rates in urban settings (42%) compared to rural settings (25%).[4]

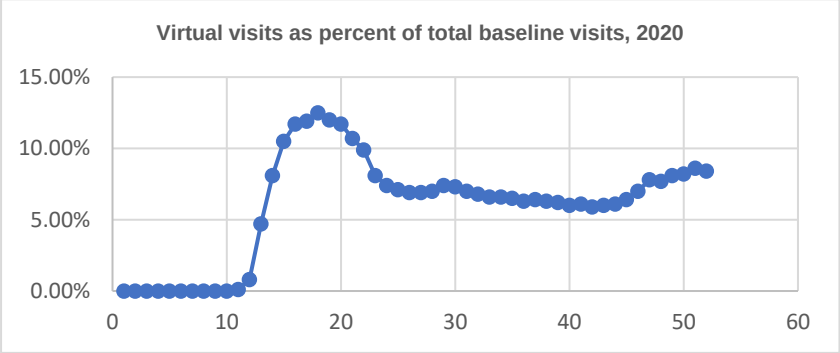
Weekly telehealth visit rates began to drop during the second half of 2020 as more patients were able to return for in-person visits. The percent of health center weekly visits delivered via telehealth declined from 36% in June, to 30% in August, to 27% in November. There are no published data on telehealth utilization rates for health centers beyond November 2020, a time period when COVID-19 cases began to rise significantly.

Outpatient Care Trends

Looking beyond health centers, it can be helpful to consider patterns in the broader market of outpatient services. To explore the expansion of telehealth in outpatient settings, researchers from Harvard University and Phreesia, a health care technology company, analyzed data on changes in visit volume for the more than 50,000 providers that are Phreesia clients. The study was based on a large convenience sample of more than 1,600 provider organizations representing more than 50,000 providers across all 50 states. The provider organizations include independent single-provider practices, multispecialty groups, federally qualified health centers, and large health systems. In a typical year, these provider organizations have more than 50 million outpatient visits, or more than 1 million visits a week.

Exhibit 3 shows the trend in virtual visits as a percent of total baseline visits[5] in 2020. The data points are weekly estimates reflecting 52 weeks in 2020. Total baseline visits were defined as the number of total visits reported during March 1-7 of 2020, just before the pandemic impact began. The chart shows a sharp rise in virtual visits to more than 12% of baseline visits by late April (week 19). The indicator dropped and began to level off over the weeks in June through October, before rising again in late fall as the next wave of the pandemic began.

Exhibit 3. Telehealth Trend Indicator for Outpatient Service Providers (National Estimates)



Source: Ateev Mehrotra et al., *The Impact of COVID-19 on Outpatient Visits in 2020: Visits Remained Stable, Despite a Late Surge in Cases* (Commonwealth Fund, Feb. 2021). https://doi.org/10.26099/bvhf-e411

[4] Demek, H.B., et. al. Trends in Use of Telehealth Among Health Centers During the COVID-19 Pandemic — United States, June 26–November 6, 2020. Morbidity and Mortality Weekly Report 240 MMWR / February 19, 2021 / Vol. 70. https://www.cdc.gov/mmwr/volumes/70/wr/pdfs/mm7007a3-H.pdf

[5] Total baseline visits were defined as the number of total visits reported during March 1-7 of 2020.

Dental Care Trends

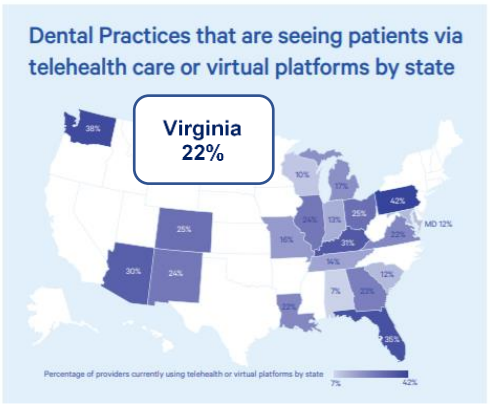
A recent report from CareQuest Institute for Oral Health (based on findings from a multi-state survey of 2,767 providers) indicates substantial support for using telehealth to deliver dental care.[6] Within Virginia, the study estimates that 22 percent of dental providers were engaged in using telehealth as of August 2020. Among all respondents from multiple states:

- 34% of providers see patients via telehealth platforms or plan to use it in the near future
- 75% of providers who use telehealth services expect telehealth encounter volume to increase or stay the same during the next 12 months
- Public health providers are more likely (44%) to use telehealth than all other practice types (21%)
- 60% of providers are using telephone calls and 42% of providers are using free virtual meeting software for telehealth encounters

The survey results also indicate that providers who experienced financial disruption and expect long-term changes to dental practice from COVID-19 were more likely to use telehealth.

Exhibit 4
Selected Findings from a Multi-State Survey by CareQuest Institute for Oral Health (2020)

Telehealth Modalities in Use for	
Telephone calls	60%
Free virtual meeting software	42%
Paid telehealth software	29%
Telehealth Dental Services Provided	
Prescribe antibiotics or medication for pain	72%
Triage patients to prioritize care	63%
Facilitate a referral	52%
Conduct a visual exam	48%
COVID-19 screening prior to visit	38%
Evaluate for risk of disease	38%
Oral hygiene instructions	37%



Health Center Insights

I have found teledentistry to be a game-changer for the care we provide. Our community is very rural and transportation to dental appointments was challenging even before COVID-19 surged in our area; while people may not always have cars, almost everyone here has a cell phone. I am hopeful for the opportunities of teledentistry, both during COVID-19 and after. The potential is great.

Source: Virginia Health Catalyst Blog Post by *Dr. Scott Wolpin, the Chief Dental Officer at Eastern Shore Rural Health System.*

[6] CareQuest Institute for Oral Health. Research Report: Provider Teledentistry Use Gains Traction During COVID-19. (2020). https://www.carequest.org/system/files/CareQuest-Institute-Providers-Teledentistry-Use-Gains-Traction-During-Covid-19-Report.pdf.

Mental Health Care Trends

It is widely known that telehealth for mental health care increased dramatically in 2020. The question is to what degree have telehealth services expanded, and what will be the likely prevalence of telehealth in the future.

To address these questions, in 2021 a team of researchers from Virginia Commonwealth University and the Veterans Affairs Health System published a national study on pandemic-based changes in delivering mental health care services. The study used a cross-sectional, national online design to recruit 2,619 licensed psychologists practicing in the United States.[7]

Exhibit 5
Self-Reported Expansion of Telehealth Use by Licensed Psychologists

Setting	*% use before COVID-19*	*% use during COVID-19*	*Projected % use after COVID-19*
Academic medical center	3.59	85.65	33.87
Group practice	5.55	88.58	34.90
Hospital/medical practice	4.37	77.98	37.56
Individual practice	8.79	89.33	36.22
Outpatient treatment facility	3.17	84.65	27.81
School/University	4.34	85.88	31.89
Veterans Affairs medical center	11.28	80.65	39.65

Source: Pierce, B.S., et. al. The COVID-19 Telepsychology Revolution: A National Study of Pandemic-Based Changes in U.S. Mental Health Care Delivery. American Psychologist. 021, Vol. 76, No. 1, 14 –25ISSN: 0003-066X http://dx.doi.org/10.1037/amp0000722

As illustrated in **Exhibit 5**, The COVID-19 pandemic has had a profound impact on mental health care delivery, shifting the vast majority of psychological services to telepsychology.

- 7.07% of psychologists reported using telepsychology before the COVID-19 pandemic, with a range of 3.17% to 11.28% across practice settings.
- The percentage increased to 85.53% during the pandemic, with a range of 77.98% to 89.33% across practice settings.
- More than a third of respondents project that they will continue to utilize telepsychology services after the pandemic, with a range of 27.81% to 39.65% across practice settings.
- A larger increase in percentage telepsychology use occurred in women, in psychologists who reported an increase in telepsychology training and supportive organizational telepsychology policies, and in psychologists who treated relationship issues, anxiety, and women's issues.
- The lowest increases in percentage telepsychology use were reported by psychologists working in rural areas, treating antisocial personality disorder, performing testing and evaluation, and treating rehabilitation populations.

Health Center Insights

Telehealth has worked very well for behavioral health. It is well-received by providers and patients, and 25-30% of our behavioral health visits are still done virtually.

Source: Health Center Listening Sessions

[7] Pierce, B.S., et. al. The COVID-19 Telepsychology Revolution: A National Study of Pandemic-Based Changes in U.S. Mental Health Care Delivery. American Psychologist. 021, Vol. 76, No. 1, 14 –25ISSN: 0003-066X http://dx.doi.org/10.1037/amp0000722

Telehealth and Health Equity

Amidst the dramatic increase in telehealth services in 2020, there were also disparities in access to telehealth for some populations. As shown in **Exhibit 6**, at particular risk for disparate access were vulnerable populations with limited digital capacity (literacy or access). Among these are rural residents, racial/ethnic minorities, older adults, and those with low-income, limited health literacy, or limited English proficiency. These population segments also tend to have higher levels of risk for adverse outcomes, including chronic disease outcomes.[8] [9] [10]

The patterns of disparity seen in 2020 were not uniform either within or across population segments. For example, some members of at-risk populations did make use of telehealth services, including video visits, sometimes at higher rates than some members of lower-risk populations. There are also unanswered questions about detailed patterns of disparity across population groups and differentiated services (e.g., medical care, dental care, mental health care, enabling services). But the overall patterns of disparity seen in 2020 raise concerns about equity of telehealth utilization in the future, especially for patients with chronic conditions.

Exhibit 6
Factors Affecting Risk for Telehealth Disparities

Patient Personal Factors
☐ Limited digital literacy (know-how) ☐ Limited digital access (computer, tablet, smart phone) ☐ Limited health literacy ☐ Limited English proficiency ☐ Rural residence ☐ Racial/ethnic minorities ☐ Older adults ☐ Low-income status ☐ Disability status
Health Care Organization Factors
☐ No pre-visit screening process for identifying patients with access challenges ☐ Limited supports for helping patients access telehealth services ☐ Requirement for patients to enroll in the patient portal to access telehealth services ☐ Inadequate language interpreter access ☐ No concerted effort to identify and triage patients best suited for telehealth or in-person services
Health System Factors
☐ Restrictions on allowable modes of telehealth ☐ Restrictions on payment for telehealth ☐ Restrictions on interstate delivery of telehealth ☐ HIPAA requirements ☐ Malpractice requirements
Community Factors
☐ Limited broadband access ☐ Limited community hot spot availability ☐ Limited community outreach and education for telehealth ☐ Limited choice in broadband providers

The available data on telehealth disparities to date has been predominantly focused on populations with health coverage through Medicare, Medicaid, Veteran's health, private health plans, MCOs, or employer-based plans. It is equally important to consider populations who are uninsured or underinsured from an equity standpoint. Members of these population segments may have distinctive capabilities and challenges for using telehealth, and these dynamics should be considered as part of an organization's telehealth strategy. This is especially important for health centers that may serve much higher numbers of uninsured and underinsured patients than their market competitors.

[8] Nouri, S., et. al. Addressing Equity in Telemedicine for Chronic Disease Management During the Covid-19 Pandemic. NEJM Catalyst, Vol. No. | May 4, 2020. https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0123
[9] Sali, R.A., et. al. No Patient Left Behind: Considering Equitable Distribution Of Telehealth. Health Affairs Blog, April 20, 2021. https://www.healthaffairs.org/do/10.1377/hblog20210414.845933/full/
[10] Vogels, Emily A. Digital divide persists even as Americans with lower incomes make gains in tech adoption. Pew Research Center, June 22, 2201. https://www.pewresearch.org/fact-tank/2021/06/22/digital-divide-persists-even-as-americans-with-lower-incomes-make-gains-in-tech-adoption/

Looking forward, structural changes will be required to eliminate telehealth disparities and achieve digital equity in telehealth. Within health care organizations, it will be important to develop systems for identifying patients at risk for digital disparity, and either assure access to in-person services or create helping relationships to facilitate utilization of telehealth services. Within the broader health care system, the bundle of payment and regulatory flexibilities authorized for telehealth utilization during the pandemic should be reviewed with an equity lens. For example, elected officials, payers, health plans, MCOs, and providers should apply an equity lens as they review policies on allowable modes of telehealth, payment for telehealth, interstate delivery of telehealth, HIPAA requirements, malpractice requirements, and other factors.

Health Center Insights

Telehealth is difficult in rural areas. Some community members have no internet or dial-up, so access is limited.

Source: Health Center Listening Sessions

Looking beyond the health system itself, broadband access is a fundamental asset for digital equity, especially video-based services. As outlined in **Exhibit 7**, within Virginia broadband access is a continuing challenge for many rural communities and the vulnerable populations who live there. A 2020 report from Commonwealth Connect (Virginia's statewide, coordinated effort to provide digital access for all Virginians) describes the variation in broadband access across Virginia, especially in rural areas.[11] There are multiple initiatives underway to improve digital access in Virginia, including federal, state, local, and private sector efforts, but these initiatives will take some time. The primary message for health centers is to understand the status of community broadband and consider supporting community efforts to increase broadband access.

Exhibit 7
Excerpt from the Commonwealth Connect Report on Broadband Access in Virginia (2020)

Broadband access in Virginia, as tracked by FCC data looks encouraging at first glance, though the numbers are misleading. According to the data, 96.9% of Virginians have access to some form of connection, 95.2% having low speed connections offering at least 10 Megabits per Second (Mbps) download by 1 Mbps upload, and 91.7% having access to a high-speed broadband connection offering at least 25 Mbps download by 3 Mbps upload.

There is good reason to believe these numbers are exaggerated, as discussed below. Separating census blocks into rural and urban classifications shows different coverage statistics. For the purpose of this report, an urban block is any census block that wholly or partially overlaps a metropolitan statistical area (MSA).

In urban areas, the coverage percentages and speed tiers are relatively consistent: ~99% have access to the internet at any speed, 98.7% have at least a slow connection (10 by 1 Mbps), and 98.1% have access to a high-speed connection (25 by 3 Mbps). In rural areas however, there is a drop-off between slow and high-speed access: 89% have access to the internet at any speed, 81.9% have access to a slow connection (10 by 1 Mbps), and 68% have access to a high-speed connection (25 by 3 Mbps).

Competition also appears to be very low among broadband providers, as companies generally invest in areas where they can be the sole source of service. In general, a lack of competition can lead to higher costs and lower service quality. Forty-seven percent of Virginians live inside a census block with one or no provider at the high-speed level (25 by 3 Mbps or above), only 52.2% have access to two or more options, and only 1.6% of Virginians have access to three or more options for service providers.

Source: Report on Commonwealth Connect: Governor Northam's Plan to Connect Virginia. Page 9. https://rga.lis.virginia.gov/Published/2019/RD109/PDF

[11] Report on Commonwealth Connect: Governor Northam's Plan to Connect Virginia. Page 9. https://rga.lis.virginia.gov/Published/2019/RD109/PDF

Telehealth and Total Cost of Care

Consideration of telehealth and its impact on the total cost of care should begin with the cost impact of health center care models prior to the telehealth explosion in 2020. Multiple studies indicate that health centers, on average, perform better than other primary care providers on measures of cost impact. To illustrate:

- A 2015 study of Medicare claims for beneficiaries in 14 states showed the total median annual costs (at $2,370) for health center Medicare patients were lower by 10 percent compared to patients in physician offices ($2,667) and by 30 percent compared to patients in outpatient clinics ($3,580). This was due to lower nonprimary care costs in health centers, despite higher primary care costs.[12]
- In another study published in 2016, analysis of Medicaid claims from 13 states indicated health center patients had lower use and spending than did non–health center patients across all services, with 22% fewer visits and 33% lower spending on specialty care and 25% fewer admissions and 27% lower spending on inpatient care. Total spending was 24% lower for health center patients.[13]

Health Center Insights

Telehealth has been an opportunity. Clinicians report elimination of transportation problems and a decrease in no-show rates. Telehealth also helps clinicians get a sense of the home environment.

Source: Health Center Listening Sessions

Focusing on telehealth, it is important to consider whether telehealth has a marginal impact (positive or negative) on the total cost of care for health center patients, especially since the 2020 pandemic. There have been no published studies on this question for health centers in particular, but a broader group of studies indicate that telehealth can have a favorable impact on the total cost of care. As one example, the Taskforce on Telehealth Policy (TTP) formed in 2020 to assess early findings and experiences under the flexibilities granted by Congress and CMS during the public health emergency. In its September 2020 report, the TTP reviewed multiple studies on the cost impact of telehealth. While each of these studies has its own limitations and should be considered provisional, when viewed as a whole it is reasonable to project that telehealth could have a favorable impact on the total cost of care going forward. Based on this review, the TTP reports that:[14]

- Virtual care could substitute for (rather than add to) up to $250 billion of current U.S. health care spending.
- In two studies conducted by health systems, 67-70% of patients reported they would have gone to urgent care or the emergency department (both more costly options) had they not had access to virtual care.
- A pre-pandemic Anthem study of Medicare Advantage claims data for acute and non-urgent care utilization found savings of 6%, or $242 per episode of care costs.
- In 2018 CMS estimated that telemedicine saved Medicare patients $60 million on travel, with a projected estimate of $100 million by 2024 and $170 million by 2029.

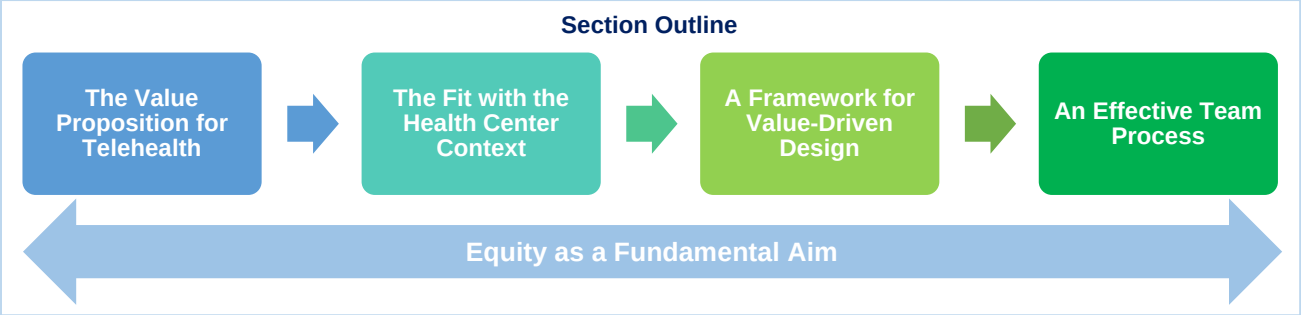
[12] Mukamel, D.B., et. al. **Comparing the Cost of Caring for Medicare Beneficiaries in Federally Funded Health Centers to Other Care Settings**. Health Services Research Volume 51, Issue 2 p. 625-64. https://pubmed.ncbi.nlm.nih.gov/26213167/

[13] Nocon, R.S. et. al. H**ealth Care Use and Spending for Medicaid Enrollees in Federally Qualified Health Centers Versus Other Primary Care Settings**. November 2016, Vol 106, No. 11 p.1981-1989

[14] Taskforce on Telehealth Policy (TTP**) Findings and Recommendations Latest Evidence: September 2020**. https://www.ncqa.org/programs/data-and-information-technology/telehealth/taskforce-on-telehealth-policy/taskforce-on-telehealth-policy-findings-and-recommendations-telehealth-effect-on-total-cost-of-care/

D. Strategic Considerations for Virginia Health Centers

The pandemic caused health centers to rapidly deploy telehealth as a stop-gap measure to assure that patients could continue receiving care. As the pandemic calms, health centers can use this window of time to decide whether and how to deploy telehealth in the future. Ideally those decisions should be guided by considerations of the potential value of telehealth services, the fit with the health center context, value-driven design, and effective team process for design and implementation.



1. The Value Proposition for Telehealth

As a starting point it is helpful to focus on value and equity when developing specific telehealth strategies. This focus will allow the team to determine whether telehealth can add value, and avoid investing time and effort in developing telehealth strategies that lack a clear value proposition.

Value can be defined in terms of key stakeholders and the associated value proposition for each. Among the key stakeholders for health centers are patients first and foremost, along with community service partners, health plans, ACOs, payers, regulators, accreditation agencies, and elected officials at the state and federal level. The specific value proposition of the health center may vary across stakeholders. At this stage, the goal is to assure you can state a clear value proposition for patients and other key stakeholder groups.

Exhibit 8 shows the elements of a telehealth value model for consideration by Virginia health centers. The model is based on the widely cited **"quadruple aim"** of enhancing patient experience, improving population health, reducing costs, and enhancing caregiver experience. **Promoting equity** is added as a central feature of the value model, with the potential to impact all four elements of the quadruple aim.

Exhibit 8
Elements of a Telehealth Value Model

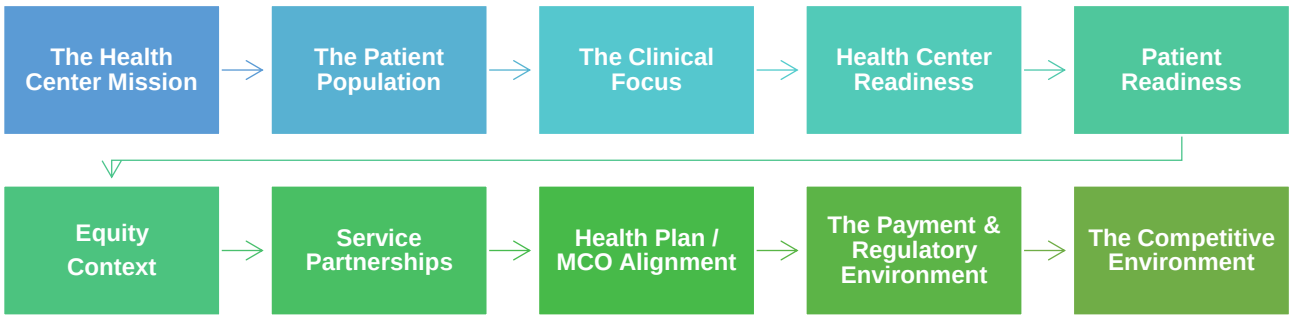
Five Questions for Team Consideration	
1.	Will this telehealth service promote equity for patients and community members?
2.	Will this telehealth service enhance the patient experience?
3.	Will this telehealth service improve population health?
4.	Will this telehealth service reduce costs?
5.	Will this telehealth service enhance the caregiver experience?

Exhibit 8 also shows a set of five questions for focusing on value and equity in designing telehealth services. The five questions represent the quadruple aim plus equity as an explicit aim of the value proposition. The questions are designed to elicit insight about specific telehealth services that are either already in place or under consideration. By asking these questions the team can determine whether the telehealth service has the potential to enhance value and equity.

2. The Fit with the Health Center Context

Having considered the value proposition for telehealth services, the next step is to consider the specific context for telehealth at your health center. Analysis of fit is important for determining whether a particular telehealth service could be a good fit for the patients, the team, and the organization. In this section we review ten factors that can influence the telehealth context for a health center in Virginia, as outlined in **Exhibit 9**.

Exhibit 9
Ten Considerations for Evaluating the Health Center Context



The Health Center Mission. HRSA defines health centers as community-based and patient-directed organizations that deliver comprehensive, culturally competent, high-quality primary health care services. Health centers also often integrate access to pharmacy, mental health, substance use disorder, and oral health services in areas where economic, geographic, or cultural barriers limit access to affordable health care services. Within Virginia each health center defines its particular mission in its own terms within the parameters outlined by HRSA. Mission matters for telehealth because health centers have distinctive patient populations and service offerings that differentiate them from other providers. Health centers should consider the fit between their specific mission and telehealth as a starting point for deciding their telehealth strategy.

The Patient Population. Health centers seek to serve all community members regardless of background. Within their patient mix are vulnerable individuals and families, including patients who may have low income, low literacy, limited English proficiency, limitations due to disability, food insecurity, housing insecurity, and limited or no access to telehealth technology. This array of factors can affect patients' readiness to engage as active participants in telehealth services. The particulars of the patient profile differentiate health centers from most other health care providers, and shapes the possibilities for implementing telehealth services.

The Clinical Focus. Health centers are required to deliver high quality, culturally competent, comprehensive primary care, as well as enabling services such as case management, referrals, translation/interpretation, transportation, eligibility assistance, health education, environmental health risk reduction, health literacy, and outreach. Some Virginia health centers go beyond traditional primary care to deliver mental health care, dental care, vision care, and other services. Telehealth can be applied in some fashion to deliver any of these services. A key consideration for 2021 and beyond is that every telehealth service that is offered should be judged as clinically effective by the clinicians at the health center.

Health Center Insights

Many clinicians did not have a positive first experience with telehealth. It may be a challenge to get them to try again.

We need focused clinical work to identify which cases fit telehealth and which do not.

Telehealth could be helpful for managing chronic illness, including remote patient monitoring and mhealth applications.

Source: Health Center Listening Sessions

Health Center Readiness. Health center readiness is the capacity of the health center to develop and deliver telehealth services as an organization. Key factors in health center readiness include adequate technology, sufficient equipment, care team readiness, and clearly defined care models for telehealth. Health centers developed these capacities on an emergency basis during 2020. A key consideration going forward is which capacities to sustain, rescale, or eliminate as part of the overall telehealth strategy.

Patient Readiness. Patient readiness refers to the will and ability of individual patients to engage in telehealth services. As noted earlier, some individual factors can negatively affect a patients ability participate in telehealth (e.g., low literacy, limited English proficiency, limitations due to disability, limited access to telehealth technology). Patients might also consider factors such as trust, privacy, and individual self-efficacy when deciding whether or not to participate in telehealth. Each of these factors can vary across population segments, and they should be considered when making decisions about providing telehealth services.

Health Center Insights

Rural telehealth can be clunky. Internet access is poor, technology literacy is low, the workflow is vast, and payment is unclear.

Pre-visit support for patients is a challenge. The need never goes away, and this level of support is costly.

Source: Health Center Listening Sessions

Equity Context. Equity of access is a key consideration for health center telehealth strategies. It can be helpful to consider equity through two overlapping lenses representing the organization and the community. Within the health center and its partner organizations, it will be important to develop systems for identifying patients at risk for disparities in access to telehealth, and assuring that policies, procedures, and communications are aligned to optimize access to telehealth for all patients who can benefit.

Looking through the community lens, one key consideration is community broadband access and its impact on equity of access telehealth. This is especially important if the telehealth application (such as video visits) requires high speed internet service. To the extent that equity concerns are identified, it will be important to optimize the telehealth system design to support equitable access, or assure equivalent access to in-person services.

Service Partnerships. The presence of ready service partnerships can be an important consideration for telehealth strategy. Clinical service partnerships for telehealth can be created between health centers and hospitals, specialty group practices, behavioral health centers, pharmacies, dental care providers, vision care providers, nutritionists, case management organizations, and other types of health and social services. Partnerships can also be created for remote delivery of clinical consultations and continuing education programs for clinicians. If these types of partnerships are not already in place, they may have to be developed in order to deliver particular types of telehealth services and supports.

Health Plan / MCO Alignment. Scaling and managing telehealth services may be easier or more difficult to the extent that health plans and other managed care organizations (MCOs) are aligned to support telehealth services. Within Virginia the support of Medicaid MCOs will be required for health centers to sustain telehealth services for Medicaid enrollees. The same is true for Medicare patients in Medicare ACOs that contract with Virginia health centers. Private health plans and employer-based programs may also vary in their approaches for supporting telehealth.

Health Center Insights

Reimbursement is a big issue.

Reimbursement must be there, or we will not do telehealth.

Source: Health Center Listening Sessions

The Payment and Regulatory Environment. In response to the pandemic, Medicare, Medicaid, and private health plans implemented specific flexibilities that would allow health care organizations to deliver services via telehealth. Two examples include authorizations to be paid for certain types of services delivered via telephone, and authorizations for licensed clinical providers to deliver telehealth services across state lines. At the current time, the future of these and other flexibilities are uncertain at best, although advocacy groups are requesting that they be continued. Resolving the uncertainty will be essential for health centers interested in delivering telehealth services in 2021 and beyond.

The Competitive Environment. Virginia health centers operate in a wide range of markets where local competition could be a consideration for providing telehealth services. The system-wide expansion of telehealth services means other providers may compete for local patients based on telehealth. As a result, the competitive landscape for health centers may extend beyond the array of local competitors to include telehealth service providers from longer distances. This competitive dynamic should be considered as health centers decide their telehealth strategies.

Health Center Insights

We need to transition to telehealth or we will be out of business. Walmart, CVS, and others are getting into telehealth. We are hiring new providers with an up-front expectation that they will provide virtual visits.

Source: Health Center Listening Sessions

3. A Framework for Value-Driven Design

If the team believes a telehealth service could be viable after considering the value proposition and the health center context, the next step is to produce a value-driven design. As three guiding objectives for value-based design, it is helpful to:

- Confirm the value proposition for telehealth
- Confirm the fit with the health center context
- Develop a patient-centered design.

Exhibit 10 shows how these three objectives can be incorporated into a **strategy checklist** for designing new telehealth services. The checklist can be used to guide design of telehealth services for medical care, dental care, mental health care, vision care, pharmacy care, enabling services, and other health-related services. The 25 checklist items represent a starting set of criteria for producing a design that is viable and sustainable for the health center. The suggested use is to apply the checklist when designing a new telehealth service or evaluating an existing service, and use the results to inform decisions and focus attention on design elements that need improvement. (This and two additional strategy checklists are provided in Appendix C.)

Exhibit 10
A Strategy Checklist for Designing New Telehealth Services

A. Confirm the Value Proposition	✓
1. This telehealth service can promote equity for patients and community members.	
2. This telehealth service can enhance the patient experience.	
3. This telehealth service can improve population health.	
4. This telehealth service can help to reduce costs.	
5. This telehealth service can enhance the caregiver experience.	
B. Confirm the Fit with the Health Center Context	✓
1. This telehealth service aligns with our mission.	
2. This telehealth services address specifically defined patient needs within the context of an overall care model.	
3. We can deliver clinically effective care through this telehealth service.	
4. Our team has the interest, motivation, skills, equipment, and broadband access necessary to deliver this telehealth service.	
5. Our patients have the interest, motivation, skills, equipment, and broadband access necessary to engage in this telehealth service.	
6. We have the necessary infrastructure in place to deliver this telehealth service (software, equipment, EHR connection, policies, procedures, and workflows).	
7. We have the service partnerships we will need to deliver this telehealth service.	
8. We have the necessary payment and policy supports from payers (Medicare, Medicaid, Veterans Health, commercial plans, employers).	
9. We have the necessary payment and policy supports from our contracted health plans and MCOs.	
10. Offering this telehealth service will give us a competitive advantage in the market for patients.	

Exhibit 10 A Strategy Checklist for Designing New Telehealth Services	
C. Develop a Patient-Centered Design	✓
1. We have the right people on the team to design or improve this telehealth service.	
2. We have clearly identified the patient population to be served with this telehealth service.	
3. We have specifically identified the patient needs to be addressed through this telehealth service in the context of an overall care model.	
4. We have considered how different patients might respond to this telehealth experience based on their clinical profile and other personal factors that may influence utilization.	
5. We have specifically considered equity in access to this telehealth service, and developed practical strategies to address equity for all who can benefit from the service.	
6. We have patient-friendly software and technology in place to support this telehealth service.	
7. We have patient-friendly workflows to help patients make appointments and prepare to utilize this telehealth service.	
8. We have patient-friendly workflows to help patients complete telehealth visits, including warm handoffs as needed.	
9. We have patient-friendly workflows to follow-up with patients on visit results and next steps.	
10. We have defined a set of key performance indicators and a process to support continuous improvement of the patient experience.	

4. An Effective Team Process for Implementing Telehealth

Whether the health center is re-evaluating an existing telehealth service or creating a new one, a team approach is essential for gaining buy-in and getting the design right. This requires an effective team process for managing design and implementation of telehealth services.

One widely applied model can be found in the **American Medical Association (AMA) Telehealth Implementation Playbook** published in 2020.[15] This model was developed in a medical care context, but it can also work for development of telehealth services in dental care, mental health care, and other service domains.

The playbook outlines twelve action steps for telehealth implementation as outlined in **Exhibit 11**. The full playbook document is 128 pages, and it provides a wealth of detail on action steps, promising practices, case examples, tools, and templates. As a quick-start guide, **Appendix C** provides a consolidated strategy checklist for getting started with an effective team process.

Exhibit 11 A Team Process for Managing Design and Implementation
Step 1. Identifying a Need
Step 2. Forming the Team
Step 3. Defining Success
Step 4. Evaluating the Vendor
Step 5. Making the Case
Step 6. Contracting
Step 7. Designing the Workflow
Step 8. Preparing the Care Team
Step 9. Partnering with the Patient
Step 10. Implementing
Step 11. Evaluating Success
Step 12. Scaling
Source: American Medical Association (AMA) Telehealth Implementation Playbook.[15]

[15] American Medical Association (AMA) **Telehealth Implementation Playbook**. Available online at https://www.ama-assn.org/system/files/2020-04/ama-telehealth-playbook.pdf

E. Ideas for Supporting Virginia Health Centers

Virginia health centers have been engaged in some forms of telehealth since well before the pandemic. The pandemic emergency caused Virginia health centers to expand telehealth at a rapid pace to continue serving their patients and communities. Looking forward, each health center will need to reconsider its telehealth strategy based on considerations of value and fit for their health center and their patients. Some will continue providing telehealth services as a core part of their service mix, while others may engage only minimally or not at all.

Based on insights provided by participants in the health center listening sessions, health centers that do decide to continue providing telehealth services could benefit from a variety of supports that could be provided or facilitated by the Association. Ideas include advocating for broadband access, advocating for supportive payment and regulation, identifying funding for telehealth technology, and supporting telehealth implementation.

Advocate for broadband access. Broadband access will be fundamental for delivering telehealth services in the future, especially video visits. The Association and its members could join efforts to advocate for expanding broadband access in underserved communities across Virginia. One option would be to engage with the Commonwealth Connect Coalition [16] and the Commonwealth Connect Initiative[17] within state government.

Advocate for supportive payment and regulation. The emergency flexibilities granted for the pandemic allowed health centers to bill and receive payment for services delivered by various modes of telehealth including telephone visits. To the extent these flexibilities are removed, the possibilities for telehealth will diminish accordingly. The Association and its members could join efforts to advocate for supportive payment for telehealth services for patients in Medicaid MCOs, Medicare ACOs, private health plans, and employer-based health plans.

Health Center Insights

Advocate at the state and federal level for improved broadband access.

Advocate for payment and funding for telehealth implementation.

Provide continuing education for clinicians and administrative staff.

Find funding for telehealth implementation.

Share best practices for workflows, billing, and admin.

We need expert consultation to think through telehealth implementation.

VCHA could help with education of clinicians and support staff.

One of our staff is getting certified in telehealth through ODU.

Source: Health Center Listening Sessions

Identify funding for telehealth technology. Health centers that engage in telehealth need an infrastructure of equipment, software, and information systems to support telehealth services. In some cases, health centers may also consider providing telehealth technology to defined groups of patients who can benefit from the service. The Association could advocate for funding to support technology development for health centers at the federal and state level.

[16] https://wired.virginiainteractive.org/content/commonwealth-connect-coalition
[17] https://www.commonwealthconnect.virginia.gov/what-is-CC

Support telehealth implementation. Telehealth services require development of specific policies, procedures, and workflows to assure patient privacy and quality of care. These requirements are evolving, and they can vary depending on the particular type of telehealth service provided. The Association could consider these ideas suggested by listening session participants:

- Provide or facilitate continuing education for clinicians and support staff on telehealth requirements and best practices.
- Facilitate access to expert consultation to help health centers optimize their telehealth strategies.
- Engage member health centers in sharing best practices for assuring quality of telehealth services, optimizing payment, and streamlining workflows, billing, and administrative tasks.

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Appendix B
Listening Sessions for Gathering Health Center Insight

Listening Session 1 June 22, 2021

Participants

- Southeastern Virginia Health System (SEVHS) Nyema King, Director of Programs
- Central Virginia Health Services, Ms. Shelia Talbott, F.N.P. Family Nurse Practitioner (Farmville)
- Central Virginia Health Services, Edie McRee Bowles, Associate Director of Development

Questions

- Q1. How has the pandemic impacted implementation of telehealth services at your health center to date?
- Q2. How has telehealth impacted patient access and utilization at your health center?
- Q3. How has telehealth impacted clinical operations at your health center? (e.g., care models, staffing model, workflows, data systems, equipment, and utilization of space)
- Q4. What are the possibilities for continuing telehealth services at your health center in 2021 and beyond, and what are the factors that will shape those possibilities?
- Q5. What types of supports might the Association provide (or facilitate) to help your health center optimize its telehealth strategy?

Listening Session 2 June 24, 2021

Participants

- Tri-Area Community Health Center - James L. Werth Jr., PhD, ABPP, CEO
- Blue Ridge Medical Center -Randy Pirtle, MHA, FACMPE, CEO
- Southeastern Virginia Health System, Pauline (Reed) Achua, MD, Chief Medical Officer

Questions

- Q1. How has the pandemic impacted implementation of telehealth services at your health center to date?
- Q2. How has telehealth impacted patient access and utilization at your health center?
- Q3. How has telehealth impacted clinical operations at your health center? (e.g., care models, staffing model, workflows, data systems, equipment, and utilization of space)
- Q4. What are the possibilities for continuing telehealth services at your health center in 2021 and beyond, and what are the factors that will shape those possibilities?
- Q5. What types of supports might the Association provide (or facilitate) to help your health center optimize its telehealth strategy?

Note: Listening session recordings have been provided to the Virginia Community Healthcare Association under separate cover.

Appendix C
Strategy Checklists

This appendix provides three strategy checklists for developing, sustaining, and expanding telehealth services, including:

1. A Strategy Checklist for Designing New Telehealth Services
2. A Strategy Checklist for Sustaining and Expanding Telehealth Services
3. A Strategy Checklist for Team Implementation of Telehealth Services

The suggested use is to convene the team and apply each checklist based on the stage of telehealth development at your health center. Any questions or comments about the checklists can be directed to Community Health Solutions at chs@chsresults.com or 804.673.0166.

1. A Strategy Checklist for Designing New Telehealth Services

This strategy checklist is designed to help health center teams assure that new telehealth services will be a good fit for patients and the organization. The key strategies are to confirm the value proposition for telehealth; confirm how telehealth fits the health center context; and develop a patient-centered design for telehealth services. The suggested use is to convene the team and consider the items in this checklist before starting a new telehealth service at your health center.

		✓
A.	**Confirm the Value Proposition for Telehealth**	
1.	This telehealth service can promote equity for patients and community members.	
2.	This telehealth service can enhance the patient experience.	
3.	This telehealth service can improve population health.	
4.	This telehealth service can help to reduce costs.	
5.	This telehealth service can enhance the caregiver experience.	
B.	**Confirm the Fit with the Health Center Context**	
1.	This telehealth service aligns with our mission.	
2.	This telehealth services address specifically defined patient needs within the context of an overall care model.	
3.	We can deliver clinically effective care through this telehealth service.	
4.	Our team has the interest, motivation, skills, equipment, and broadband access necessary to deliver this telehealth service.	
5.	Our patients have the interest, motivation, skills, equipment, and broadband access necessary to engage in this telehealth service.	
6.	We have the necessary infrastructure in place to deliver this telehealth service (software, equipment, EHR connection, policies, procedures, and workflows).	
7.	We have the service partnerships we will need to deliver this telehealth service.	
8.	We have the necessary payment and policy supports from payers (Medicare, Medicaid, Veterans Health, commercial plans, employers).	
9.	We have the necessary payment and policy supports from our contracted health plans and MCOs.	
10.	Offering this telehealth service will give us a competitive advantage in the market for patients.	
C.	**Develop a Patient-Centered Design for Telehealth**	
1.	We have the right people on the team to design or improve this telehealth service.	
2.	We have clearly identified the patient population to be served with this telehealth service.	
3.	We have specifically identified the patient needs to be addressed through this telehealth service in the context of an overall care model.	
4.	We have considered how different patients might respond to this telehealth experience based on their clinical profile and other personal factors that may influence utilization.	
5.	We have specifically considered equity in access to this telehealth service, and developed practical strategies to address equity for all who can benefit from the service.	
6.	We have patient-friendly software and technology in place to support this telehealth service.	
7.	We have patient-friendly workflows to help patients make appointments and prepare to utilize this telehealth service.	
8.	We have patient-friendly workflows to help patients complete telehealth visits, including warm handoffs as needed.	
9.	We have patient-friendly workflows to follow-up with patients on visit results and next steps.	
10.	We have defined a set of key performance indicators and a process to support continuous improvement of the patient experience.	

Notes

2. A Strategy Checklist for Sustaining and Expanding Telehealth Services

This strategy checklist is designed to help health centers build capacity to sustain and expand telehealth services over time. The keys strategies are to integrate telehealth into the health center strategy, organizational supports, team development, and quality. The suggested use is to convene the team and use this checklist to assure telehealth services can be sustained and expanded over time.

A. Strategic Integration	✓
1. Consider patient perspectives on interest in utilizing telehealth in the future.	
2. Conduct financial analysis to project financial impact of telehealth services.	
3. Conduct market analysis to assess potential demand and competition for telehealth services.	
4. Identify priority clinical sites and services for telehealth implementation and expansion.	
5. Establish strategic objectives for telehealth within the health center strategic plan.	
B. Organizational Support	✓
1. Assure leadership support for telehealth, including CEO, CFO, CMO, and CIO.	
2. Identify and acquire telehealth equipment and software to support long-term sustainability and growth.	
3. Design necessary workflows for patient support and telehealth delivery in specific clinical sites and services.	
4. Update organizational policies and procedures for telehealth delivery and billing.	
5. Align EHR and other information systems to support telehealth delivery and billing.	
C. Team Development	✓
1. Engage health center team members as key informants and partners in sustaining and expanding telehealth services.	
2. Integrate telehealth into coaching, mentoring, and training for team members.	
3. Integrate telehealth into job descriptions and personnel evaluation.	
4. Integrate telehealth into onboarding programs for new staff.	
5. Integrate telehealth into recruitment, interview processes, and hiring decisions.	
D. Quality Assurance and Performance Improvement	✓
1. Identify where telehealth services are used to support specific patient care models that are focal points for quality measurement within the health center (e.g., diabetes, hypertension, prenatal care, childhood immunization, cancer screening).	
2. Develop a quality assurance and improvement (QA/QI) framework for telehealth services (consider using the **National Quality Forum** framework as a starting point).[18]	
3. Focus QI efforts on optimizing the patient experience with outreach, education, triage, care delivery, and follow-up for telehealth visits.	
4. Refine the QA/QI framework to enable assessment of disparities in patient access, utilization, and satisfaction with telehealth services.	
5. Integrate the QA/QI framework for telehealth services into the overall QA/QI plan for the health center.	
Notes	

[18] The National Quality Forum framework identifies four domains for telehealth quality, including access to care, financial impact/cost, experience, and effectiveness. https://www.qualityforum.org/ProjectDescription.aspx?projectID=83231

3. A Strategy Checklist for Team Implementation of Telehealth Services

The source for this checklist is the **American Medical Association (AMA) Telehealth Implementation Playbook** published in 2020.[19] This model was developed in a medical care context, but it can also work for implementing telehealth services in dental care, mental health care, and other service domains. The full playbook document is 128 pages, and it provides a wealth of detail on action steps, promising practices, case examples, tools, and templates. This appendix provides a consolidated strategy checklist for implementing telehealth in a team context.

Step 1. Identifying a Need

- ☐ Solicit feedback from staff to identify the biggest pain points and opportunities that exist in your
- ☐ organization
- ☐ Identify areas of opportunity from patients via satisfaction and/or experience survey responses
- ☐ Prioritize your list of pain points and opportunities based on severity of need and fit with the strategic goals of the organization
- ☐ Identify problems that are most likely to be resolved by a telehealth solution
- ☐ Select a problem that, if solved, would have the greatest value to your entire organization and patients
- ☐ Identify what type of telehealth service could be offered to solve this need (e.g., 1:1 follow-up care, connection to specialists, group education)
- ☐ Evaluate your organization's overall readiness for a telehealth solution
- ☐ Envision the expected outcome(s) if that problem were addressed
- ☐ Identify legal, regulatory, or financial restraints that could get in the way of solving this need (e.g., reimbursement, interstate licensure, data use, and ownership)
- ☐ Begin to establish a budget and funding source

Step 2. Forming the Team

- ☐ Identify the key members of your Core, Leadership, Advisory, and Implementation teams
- ☐ Host a kickoff meeting to outline and communicate the responsibilities and time commitment required of each team member
- ☐ Discuss financial, IT, and legal considerations at kickoff meeting
- ☐ Set clear dates for Cross-Committee action on Selecting a Vendor, Making the Case, and First Implementation
- ☐ Set up regular meetings with your Core team
- ☐ Solicit input from your Implementation team
- ☐ Set key checkpoints with the Advisory team at least one month in advance to stay on schedule
- ☐ Pre-seed your program intent with key members of your Leadership team
- ☐ Set up weekly emails to make sure communication is open between teams and departments

Step 3. Defining Success

- ☐ List benefits of your telehealth program for patients, clinicians, and your organization as a whole
- ☐ Reground yourself in the financial, legal, and operational limitations your stakeholders have identified, especially reimbursement and interstate licensure limitations
- ☐ Research the types of results that are feasible with the solution you are considering
- ☐ Identify 3–5 goals that are most important for your entire practice or organization (e.g., continuity of care, reimbursable interactions, appointment compliance, patient satisfaction, physician satisfaction, access to care)
- ☐ Identify which metrics are most appropriate for assessing progress toward these goals
- ☐ Ensure each goal is S.M.A.R.T.
- ☐ Set up a process or system to collect data and track progress against the goals (keeping in mind that vendors' platforms may have analytics capabilities)
- ☐ Establish specific checkpoints to collect data
- ☐ Set clear endpoint criteria to reevaluate as needed or to scale the program
- ☐ Plan for how and when you'll establish baseline metrics as a comparison point for your program's success
- ☐ Plan for how and when you'll evaluate success after initial implementation

[19] American Medical Association (AMA) Telehealth Implementation Playbook. Available online at https://www.ama-assn.org/system/files/2020-04/ama-telehealth-playbook.pdf

Step 4. Evaluating the Vendor

- Begin with your network, including asking for word-of-mouth referrals from experienced practices early on and researching third-party reviews
- Research potential vendors
- Build a Request for Proposal (RFP), clearly outlining the goals you identified in Step 3
- Send RFPs to vendors that most closely align to your goals
- Review RFP responses alongside key representatives from the Core and Advisory teams
- Ask for case studies and referrals
- Schedule live vendor demos with select members of the Core, Advisory, and Implementation teams
- Evaluate vendors across six critical factors: Business, Information Technology, Security, Usability, Customer Service, and Clinical Validation
- Narrow your options to one or two preferred vendors to include in your pitch to leadership
- Use established criteria to make the evaluation process simple for leadership when Making the Case (Step 5)

Step 5. Making the Case

- Clearly define resources needed to move forward with this implementation (funds, additional staff, additional bandwidth, political support, official approval, etc.)
- Estimate the budget required to obtain the resources to implement your program, including vendor services, equipment, marketing, education, EHR integration, additional personnel resources, etc.
- Estimate the value your solution will contribute to the organization if goals are achieved
- Finalize the plan for a path to payment in collaboration with finance, contracting, and other appropriate team members
- Calculate the ROI of your implementation, considering the budget and value you've estimated
- Align your implementation with organizational objectives/goals to justify why this is a priority
- Research coding and payment available for your chosen digital health solution and assess your liability and risk
- Reach out to malpractice insurance carrier to ensure proper coverage
- Compile all necessary information in a proposal to the key decision-makers to obtain approval and resources to support your implementation

Step 6. Contracting

- Secure any remaining approvals within your organization to proceed with contracting
- Negotiate terms (financial investment, customer support, additional services, upgrade schedule, success metrics, etc.)
- Document clear and measurable definitions of success for your working relationship and the initiative at large
- Identify the timeline for the current contract and outline when terms will be renegotiated
- Clearly outline the plan to scale your program, and align on any relevant contingency plans
- Work with your legal, financial, procurement, or IT teams as necessary to get the new contract signed or existing contract updated

Step 7. Designing the Workflow

- Engage the Implementation team to provide input on workflow design
- Solicit feedback from patients to understand their needs, times of day that may work best for appointments, and barriers they may have to engaging in a telehealth visit
- Document your existing clinical and administrative workflow and identify where updates may be necessary
- Identify updated procedures, such as patient and case identification, appointment scheduling, patient training, appointment logistics, consent, platform assistance, and billing
- Ensure care will still be provided in a fully legally compliant way (e.g., follows fraud and abuse laws, privacy standards, and other applicable legal requirements)
- Define clear triage protocols for when a telehealth appointment is appropriate and ensure the clinic staff and scheduling teams are trained to distinguish when it is an acceptable alternative to an in-person appointment
- Identify what support clinicians and staff will need to effectively complete a telehealth visit
- Assign clear roles and responsibilities for any new actions necessary for integration
- Document a new workflow that incorporates necessary changes
- Partner with your vendor to identify opportunities for efficiency (e.g., patient communication, rooming, etc.) based on your team's needs
- Engage your IT team and/or vendor to understand how to best integrate your workflow into your EHR and establish a plan for emergency tech support

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Step 7. Designing the Workflow (continued)

- ☐ Develop resources to support and socialize the new workflow (written procedures for each department, communication templates)
- ☐ Create a proper environment that will support successful telehealth visits (e.g., strong Wi-Fi connection, sufficient internet bandwidth, quiet/private space, clear video of clinician)
- ☐ Conduct internal telehealth test visits
- ☐ If you've introduced new technology, make sure you conduct a HIPAA Security Risk Assessment
- ☐ Collect patient and staff feedback and iterate as necessary

Step 8. Preparing the Care Team

- ☐ Talk with your vendor about available training support
- ☐ Identify staff leads who can develop, position, and socialize training materials
- ☐ Identify "superusers" who can act as ongoing trainers for other staff and physicians, especially as you scale
- ☐ Develop (or source from your vendor) written and/or video training materials (scripts, guides, reference documents) that staff can use and refer to
- ☐ Schedule training session(s)
- ☐ Plan for how and when training will be refreshed/reviewed as needed
- ☐ Educate staff on the new workflow, clinical protocols, and operation of the telehealth platform
- ☐ Include telehealth training for new hires
- ☐ Train staff to educate patients (see Step 9: Partnering with the Patient for tools)
- ☐ Conduct internal telehealth test visits
- ☐ Provide a process/opportunity for staff to provide ongoing feedback to optimize workflow
- ☐ Develop a process for onboarding new staff in the event of turnover

Step 9. Partnering with the Patient

- ☐ Develop (or source from your vendor) a wide variety of patient educational materials to support different learning styles
- ☐ Finalize patient eligibility criteria for engaging in a telehealth appointment
- ☐ Program final patient eligibility criteria into scheduling algorithm
- ☐ Market the eligibility criteria to patients with use cases best suited to be addressed using telehealth
- ☐ Finalize training protocols and educational materials for patients to participate in telehealth appointments
- ☐ Ensure you are prepared to initiate workflow for telehealth appointments

Step 10. Implementing

- ☐ Officially launch the program with some initially scheduled patient visits
- ☐ Be prepared to support patients with any scheduling or technical issues during the visit
- ☐ Be prepared to support physicians and care team members with technical issues during telehealth visits
- ☐ Ensure your patient intake flow is working as intended in your workflow design
- ☐ Solicit post-visit feedback from staff and patients; adjust procedures as necessary
- ☐ Ensure you are tracking key success metrics outlined in Step 3 (Defining Success)
- ☐ Evaluate how documentation and billing procedures are working; adjust as necessary

Step 11. Evaluating Success

- ☐ Gather data used to track your key success metrics
- ☐ Collect feedback from your Implementation team
- ☐ Determine your success by comparing this data to the pre-implementation baseline
- ☐ If failing to meet goals, revisit your process to identify hurdles to success; rework and iterate as necessary
- ☐ If succeeding, gather compelling success metrics into an expansion proposal
- ☐ Consult your Core and Leadership teams to determine the program's future
- ☐ Align on goals for next iteration or phase of the program

Step 12. Scaling

- ☐ Resolve any improvement opportunities identified in the initial implementation
- ☐ Socialize the success of the telehealth program throughout your organization to generate enthusiasm
- ☐ Select your next scaling prospect (i.e., more patients, different visit type, new specialty, etc.)
- ☐ Budget and secure financing for growth, depending on your vendor contracting model
- ☐ Negotiate the next phase of your partnership with your vendor
- ☐ Adjust workflows to account for program growth
- ☐ Retrain staff or train new staff to account for program growth
- ☐ Engage new patients
- ☐ Continue tracking key success metrics for ongoing impact