IMPACT
Virtual First Medical Practice Collaboration

GUIDE TO VIRTUAL FIRST CARE (V1C) PAYMENT MODELS

GETTING STARTED WITH THIS GUIDE

This guide tailors approaches to value-based payment models to unique aspects of virtual first care (V1C), providing payers and V1C solutions guidance on which payment models they should be using (or working toward using) in their arrangements. It also highlights the ways that V1C components, especially software, are enabling flexibility, data, and transparency in pricing models across the board.

As you review this resource, please note:

- A V1C may simultaneously offer multiple payment models for various product offerings. Sometimes multiple payment models will be combined in one solution depending on the level of service a member uses.
- The payment model a payer-V1C contract initially uses may evolve over the course of the relationship in subsequent phases of contracting even within the same solution.

	PPPM - Per Participant per Month *(Where a participant is a person who has joined a V1C service.)*	**Per episode of Care**	**PMPM/PEPM** - Per Member/Enrollee per Month *(Where a member is an active plan member at a payer.)*	**FFS** - Fee for Service
Best Suited for	V1C solutions that support chronic disease management where longitudinal care is needed	V1C solutions that support completing a course of treatment for a given health episode (can be one time or recurring)	V1C general wellness solutions that are applicable to a whole covered population, or to a population where a certain estimate for utilization can be provided (ex 911 services)	Individual, visit-based services that are covered by traditional Current Procedural Terminology (CPT) codes.
Billing Details	Monthly; Billed as per participant enrolled in the V1C solution	Per episode / milestone as accrued (may limit total # of episodes covered in a plan year)	Monthly; Billed as per participant enrolled in the plan	Continuous; Billed as service is provided and claims are submitted
V1C Best Practices and Pitfalls	*Key Features/Best Practices* ★★★ **Clearly define engagement on and off ramps.** Clarify definition of what counts as one engaged participant and when that engagement ceases. This then dictates what triggers billing and discontinuation of billing. Where tiered pricing exists, **ensure mutually-exclusive segmentation between the tiers.** *Tried/Not ideal* ☆☆☆ **Ill-defined engagement metrics**. Needs to be discreetly measurable to allow for easy counting.	*Key Features/Best Practices* ★★★ **Define a clear milestone or engagement metric to trigger start/end of an episode.** Determine a leading indicator to give confidence that the member is achieving a specific outcome to mark the start and define a reasonable moment of completion for the end of an episode. **Delineate the scope of the bundle.** Must be clear what is included and what is not. **Define participant offramp experience options.** Will the participant go into a V1C follow on maintenance offering? Will they be transitioned to a brick and mortar provider? **Define criteria for the start of a second/subsequent episode.** What is the clear threshold that a member will pass to justify starting another episode of care?	*Key Features/Best Practices* ★★★ **Payer should be attentive to leakage**. To address concern that V1C solution is providing service to a member whose coverage has lapsed, the payer should be monitoring when they are no longer covered. *Tried/Not ideal* ☆☆☆ **Billing using both medical and admin spending.** Avoid at all costs since the nature of V1C provided is all medical care, billing some portion to admin is particularly problematic in medicare/medicaid programs where admin spend is closely monitored.	*Tried/Not ideal* ☆☆☆ **Incentivizes maximizing utilization, not achieving an outcome**, in order to make the economics work for the V1C provider. **Doesn't contemplate a continuous care model** which makes V1C solutions ill fit since they aren't episodic in nature. **Many components of V1C don't fit into coding**: app-based activities, coaching, async interactions, RPM to name a few.

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Use/ Trends	**These models are widely preferred by payers** who see it as a way to pay for utilization, while bundling payments to allow for accounting for the fact that V1C is not purely visit-based. Further, **these models allow for measured risk sharing** (and upside for outcomes-based performance) for both parties. Generally, as V1C's become more established, payers trust them to assume more risk. Payers generally consider three interrelated questions: (1) How much evidence is there/how sure is it that we will get the promised outcome? The earlier stage the V1C, the less evidence, the less risk a payer is willing to assign. (2) What is the timing of the payment? (3) How much does it cost? Payment models in these categories should **guarantee a bare minimum outcome and a maximum dropout rate**. Anything over/under these thresholds would have a bonus or penalty. Payment for brick-and-mortar providers should generally be avoided in the bundle unless the V1C is fully capitated — then V1C should pay for all providers regardless of setting.		**Payers generally don't prefer this model since it's paying for services not rendered** and requires the payer to assume significant risk.	**Hard to figure out economics of V1C services** since some V1C models are bundling reimbursed and unreimbursed services, along with those chronically under-reimbursed. **Reimbursement policies for telehealth and specific services are so highly variable across payers** that it's hard to build a business model that works consistently. Variations in what's reimbursed and for how much and with what codes add significant administrative and operational complexity and cost to V1C providers.

A NOTE ON PATIENT FEES ASSOCIATED WITH THESE MODELS

The cost to V1C participants goes hand-in-hand with the selection of the right payment mode. Ideally, participants would not incur fees and payers would fully cover the costs of V1C. However, this is not currently possible through all plan types. As new innovations in care are developed, regulation should allow for more flexibility for plans to decide when and where they want to make an exception and waive patient responsibility for costs where it would otherwise be required. In the case of high deductible health plans, for instance, where V1C may not qualify as a wellness expense, patients would be responsible for paying out-of-pocket for a V1C solution, adding what could be argued as an expense barrier for people who seek to get the best care.