Virtual First Care Coalition by Digital Medicine Society

Guide to Virtual Care First (V1C) Payment Models

Getting Started with this Guide

This guide outlines approaches to value-based payment models to unique aspects of virtual first care (V1C). It provides payors and V1C solutions guidance on which payment models they should use (or work toward using) in their arrangements. It also highlights how V1C components, especially software, enable 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, combining several payment models into one solution depending on the level of service a member uses.
- The payment model a payor-V1C contract initially uses may evolve throughout the relationship in subsequent contracting phases, even within the same solution.

	PPPM— Per Participant per Month *(Where a participant is a person who has joined a V1C service.)*	**Episode of Care**	**PMPM/PEPM—** Per Member/Enrollee per Month (where a member is an active plan member at a payor).	**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 apply to a whole covered population or to a population where a particular estimate for utilization can be provided (e.g., 911 services)	Individual, visit-based services are reimbursable using 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 after a provision of services and claims are submitted.
V1C Best Practices and Pitfalls	*Key Features/Best Practices* ★★★ **Clearly define engagement on and off ramps.** Clarify what counts as one engaged participant and when that engagement ceases, which will dictate 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**. It needs to be discreetly measurable to allow for easy counting.	*Key Features/Best Practices* ★★★ **Define a clear milestone or engagement metric to trigger the 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.** It must be clear what the bundle includes and what it does 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 starting a second or subsequent episode.** What threshold must a member pass to justify starting another episode of care?	*Key Features/Best Practices* ★★★ **Payors should be attentive to leakage** and monitor coverage end dates to address concerns that the V1C solution provides service to members whose coverage has lapsed. *Tried/Not ideal* ☆☆☆ **Avoid billing using both medical and administrative spending** at all costs. Since the nature of V1C provided is all medical care, billing some portion to administrative spending is particularly problematic in Medicare/Medicaid programs that closely monitor administrative expenditures.	*Tried/Not ideal* ☆☆☆ **Including incentives to maximize utilization rather than achieve an outcome** that will make the economics work for the V1C provider. **It doesn't contemplate a continuous care model, which makes V1C solutions unsuitable** since they aren't episodic. **Many components of V1C do not meet the current coding requirements**, such as app-based activities, coaching, and asynchronous interactions.

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Use/ Trends	**These models are widely preferred by payors**, who see them as a way to pay for utilization while bundling payments to account 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, payors trust them to assume more risk. Payors typically consider three interrelated questions: (1) How much evidence is there/how sure is it that we will get the promised outcome? The earlier the stage of the V1C, the less evidence the less risk a payor 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. Bundles should only pay for brick-and-mortar providers if the V1C is fully capitated. Then, V1C should pay for all providers regardless of setting.		**Payors generally don't prefer this model since it's paying for services not rendered** and requires the payor to assume significant risk.	**It is difficult to determine the economics of V1C services** since some models bundle reimbursed and unreimbursed services and those chronically under-reimbursed. **Reimbursement policies for telehealth and specific services are inconsistent across payors,** making it challenging to build a consistent business model due to variations in what services receive reimbursement, 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 selecting the proper payment mode. Ideally, participants would not incur fees, and payors would fully cover the cost of V1C. However, this is only currently possible through some plan types. As innovations in care continue to develop, regulation should allow for more flexibility for plans to decide when and where to make an exception and waive patient responsibility for costs where otherwise 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 qualify as an expense barrier for people seeking the best care.