# Contract Reimbursement Models

## Introduction

In this chapter we will review the three most common reimbursement models utilized by payers (Fee for Service, Per Member Per Month, and Value Based) and also analyze the risk that is associated with your contracts. This chapter will cover the nuances of each reimbursement model along with the best ways to use your practice information to effectively analyze risk and negotiate your commercial contracts.

### Key Takeaways

I. Know the various reimbursement models and the specific elements
II. Understand the data elements that are important to each model
III. Understand the risk in your contracts and how to capture it

## Section 1.0 - Fee for Service (FFS) overview

1.1 - Fee for service remains the most common reimbursement model in the current insurance market and the majority of your commercial contracts are likely built around this model. This model provides a fee for each approved and medically necessary clinical service. Since FFS is focused on payment per service, you will want to focus on the "bread and butter" for your practice. What services do you provide the most? What services do you provide better than others? Make note of these services for conversations with the payers.


*If you are part of a larger organization, like an IPA or a clinically integrated network, you should work with members of that organization to obtain copies of your contracts. Even though they handle your contracts, you should have copies of that information.*

1.2 - Every practice has a "Bell Curve" of performed services. Again, what services you provide the most and what services you provide the least. Being a primary care practice, you likely bill a lot more evaluation and management codes than procedure codes. Analyze the bell curve for your practice to help focus on the services you provide the most.


*These codes can be used based on the documentation of history, exam, medical decision making, and the time spent counseling and coordinating care.*

Use your data to support your claims by showing payers the number of these services you render to their members. You may also want to perform a cost accounting function to find out your actual costs of performing each service. Take labor costs for example: if your practice is in a rural area, where labor costs are high, you can use that associated data to prove the need for higher reimbursement in order to afford additional providers for your practice.

1.3 - Helping payers understand your costs, your outcomes, your availability (like evening and Saturday hours), and your results are all valuable data elements utilized when you discuss rates in this model. The payers have no idea how happy your patients are, how large your capacity is, your availability for urgent matters, or your ability to also provide mental and behavioral health services unless you tell them and show them with good, replicable, simple to understand data.


*The mantra for Fee for Service contracts is "**Do What You Do Best**." The key is to prove that you are the best by using tangible data from sources like your EHR, data aggregation tools, and claims data to support your argument for greater reimbursement.*

## 2.0 - Per Member Per Month (PMPM) overview

2.1 – Per Member Per Month, also called *capitation*, is an old methodology which is making a big comeback as the market begins to shift away from the traditional Fee for Service model. The PMPM model focuses on managing the health of populations by treating those members who are attributed to your practice. Commercial payers will then pay a set amount per month for each patient that is assigned, or attributed, to your practice and providers. As you very well know, patients have the option to designate a primary care provider of their choice, which leads to attribution. Member attribution is incredibly important and needs to be constantly monitored so that it remains accurate. Inaccurate attribution reports need to be vigorously challenged, because it can directly affect the practice and providers. See the example below:

**Example:** Emily Johnson has recently moved to Colorado and has selected Dr. Smith as her PCP only because the practice location is close to her home. Emily has never seen Dr. Smith and has no intention to do so, as she has no immediate health issues. By selecting Dr. Smith, Emily, and her associated costs, become "attributed" to Dr. Smith and her practice.

If Emily goes to the Emergency Room, those associated costs are then attributed back to Dr. Smith even though she had no input on this patient's care.

Keep this in mind when reviewing those patients that are attributed to your practice. If a patient that you have never seen is on the list, you might reach out to that patient to schedule an appointment.

2.2 - A PMPM model contains, at its core, a certain level of financial risk. The payer is paying a per-member-per month fee whether you see the patient or not. This is a pretty good deal if you help keep your patients well! Be aware, this model can have a downside if you manage a small patient population that requires frequent care. Most PMPM arrangements are, therefore, age/sex adjusted and only available when a certain threshold of volume exists. Keep in mind, older patients and those who have chronic issues should carry a higher PMPM payment than those who are younger and healthier. Use your internal information to share this with the payers when structuring your PMPM payments.

**Example:** A 21-year-old male with no medical issues, may come in only once a year and he will have a lower associated cost than a 70-year-old male who is hypertensive with diabetes.

The 70-year-old male will carry a higher PMPM payment because you need to spend additional resources in order to care for this individual.

2.3 - Primary care providers should be reimbursed accordingly for managing their patient populations and this is where we see the PMPM model come in to play. This is a great opportunity for primary care practices when it comes to providing behavioral and mental health services by integrating your practice setting. Considering that PCPs assume responsibility for their patients' health, the PMPM model incentivizes practices to take on this responsibility. It is important to use your data effectively in order to make the most of PMPM payments. You can use data straight out of your EHR system to analyze trends in your population and focus on those high cost drivers, because your patients who require the most care will likely be the most expensive. Focus on these patients to help drive down their overall cost and then capitalize on your PMPM payments. As an added benefit, you can show payers that you are providing behavioral and mental health services which can then lead to a higher PMPM payment for managing your patients at a deeper level.


*Mixed models exist in payer contracting. You may have an opportunity to negotiate a FFS contract with an additional PMPM payment on top. This type of mixed model is valuable to PCP practices when integrating Behavioral Health services, because you can carry the PMPM payment for managing those specific patients.*

## 3.0 - Value Based/Share of Savings overview

3.1 - Payers base their premiums on an estimate of total cost of care and they use various actuarial information and historical data to do so. If a provider, or provider group, is able to lower the overall cost of care for their attributed lives, then the payers may be willing to share those savings with the provider or provider group. This is the foundation for value based, or shared savings, contracting and it can be a great partnership! This concept can also be very frustrating if not understood completely. The payers will likely have a lot of reporting and quality requirements, so transparency is paramount for success in this model. This reporting piece is something you are already doing through SIM by collecting and reporting your Clinical Quality Measures (CQMs). Understanding your CQMs and how to collect that information gives you an advantage, but make sure you work with the payers to understand what specific measures you need to track and how they would like that information reported back to them.

3.2 - Often times, these arrangements are fairly simple to understand. If you are able to provide services for less than the predetermined target spend, then you have the opportunity to share in those savings. See the example below:

**Example:**

Population = 2,500 members

Target Spend = $500,000/year to manage the population

The contract states that the health plan will share back 40% of total savings to your practice. You are able to manage this population for $400,000 which means there is $100,000 in savings and the health plan will then share back $40,000 to your practice.

The key to success here is to track how well you are doing. A transparent relationship with the payer, where you both share information back and forth, will help you stay on top of your results and ultimately meet your goals. A good payer relationship is a true partnership where both parties work together to manage high cost drivers, specifically sick patients and out of network costs. Tackling these high cost drivers together leads to more savings which in turn brings higher reimbursement back to your practice.


*A strong relationship with local hospitals is also very helpful in these arrangements! Knowing when your patients are admitted and when they utilize the emergency room is a great way to help control costs.*

3.3 - Be careful to identify "***race to the bottom***" arrangements! Payers may reset the target spend rate each year to continually lower the budget for a population. In line with the example in *section 3.2*, you beat the budget in year one and shared in those savings. Now, in year two, they reset the target budget to incorporate year one's savings and expect you to beat it again. This is a race to the bottom! If this language is included in your contract, you will reach a point where you can no longer save the health plan any more money and you will end up with no share of savings after you have done all the hard work. Keep an eye out for this structure and have a conversation with your payers about not decreasing the target budget in order to avoid this scenario.

## 4.0 – Analyzing risk in contracting

4.1 – Fully insured health plans are in the risk business. They collect monthly premiums for a set (and documented) list of benefits. As we move away from the Fee for Service world, other reimbursement methodologies that are based around more risk are becoming attractive for practices, providers, and payers. More often than not, this entails the transfer of some of the payers' risk to the provider. As we can see in both the PMPM and Value Based models described above, risk-based contracts increase the responsibility for practices and providers, but, *and this is the important part*, it should come with additional payment to your practice for taking on more of that risk.

4.2 - There can be upside risk and downside risk. Upside risk is for the more immediate future and it is much more common in contracts because it carries less financial hazard for both sides. Downside risk is based on longer term relationships and must involve far greater numbers in order to actually work, so this concept is typically used with larger groups and IPAs. In an up-side risk arrangement, you would be eligible for up-side potential. In an up-side/down-side arrangement you are eligible for the up-side but also may have to pay money back if there is a deficit. Talking about risk is where your practice data is of paramount importance to manage both cost and quality. The risk in your contracts shifts financial responsibility to your practice and you must pay more attention to the total spend. Using data aggregation tools here will help you analyze your information at a deeper level to truly understand where these costs are coming from. Your patients that cost the most money will likely make up a small percentage of the total population you serve and you can use data aggregation tools to identify these patients and then work with them to help balance the overall spend.

4.3 – With risk in mind, it is no longer about how many procedures you perform, but how well you perform them, where they are performed, the cost, and the outcome. In risk agreements you are at risk for the overall spend, the outcomes, and the patient's satisfaction. In a pure risk environment, it matters less about what you bill and more about the ultimate outcome of total cost and patient satisfaction. Be careful! Ask any and all questions about the risk in your contracts. Most payers will not allow a group who is not ready to enter into a pure risk deal. They do not want you to fail and they will work with you to help you better understand risk.


*Risk exists in all contracts! Because insurance is a "risk business" you need to be aware of these aspects and your costs to make sure you are being payed appropriately for the services you provide.*

## 5.0 - The importance of data

5.1 - Data is everything! Being able to analyze large data sets and then follow those trends is incredibly important. This information gives you an idea of how you are preforming over time and you can use that to show the payers your value for their networks. Using data aggregation tools is a great way to analyze large data sets much more in depth by focusing on patients with chronic conditions or by looking at your high cost drivers. At the same time, some of the most important data out there is readily available to you through your EHR system. You have real time data available in your practice before it can be processed and reviewed by the health plans. This puts you a few steps ahead of the game. Use your own internal reporting capabilities coupled with information from your data aggregation tools to help you when you have conversations with your payers and to show them your analysis.

5.2 - Understanding and showing the payers how you can control costs is incredibly valuable and you have the tools to do so. A majority of what you do in your office is fairly inexpensive in the grand scheme of things because most of the cost (payers call it '*the spend'*) is not in your office. The real spend is at the pharmacy, the emergency room, with specialty physicians, in the hospital, imaging, etc. The real costs in health care exist because of the services you order or refer to. With that being the case, you, as a PCP, hold an incredible amount of power in your referrals and your knowledge of where your patients are going. Use that information to identify where the high costs are coming from, and then show the payers that you can save them a lot of money by directing these services. Now that they know you can save them money, you have the opportunity to capitalize on a higher reimbursement. Showing a payer how you understand and can, therefore, control costs is incredibly valuable and, frankly, impressive to them; however, you cannot just talk about it. You have to be able to actually do it, show it, and understand it.


*It should be noted that not <u>all</u> of this cost is within your control. For example: "hot spotters," patients who go to the ER a lot, are incredibly expensive and they may seek out additional services without your knowledge and/or before consulting with you.*

5.3 - Understanding your own data, your trends, your patient volume and demographics is key to making the most of your reimbursement. If you have a stable patient base and you have good information on them (age, sex, medical history, etc.) you may be comfortable entertaining a value-based contract which allows for additional payments based on results. For example: If you can lower the utilization of name brand medication and can track this, you are on your way to being capable of having value-based contracts. You need a payer partner who also has good, actionable data which they are willing to share transparently. Transparency is key to success in this partnership which will lead to success when contracting.

**Please fill out the survey included in the link below. Tell us what you think!**

**Survey Link: https://www.surveymonkey.com/r/9QR6SPV**

***Worksheet attached on next page***

## Chapter 2 Worksheet

This worksheet is meant to help you organize your current contracts and then analyze those rates and terms. Read through your current contracts to determine the rates and reimbursement methodologies that you have with some of your current commercial payers. If you do not have your commercial contracts on file, you can reach out to the payers to obtain executed copies. The table below is broken down into four categories for contract review:

**Payer Name** – Which payer contract you are reviewing.

**Reimbursement Rate** – You should note that some products and plans will be broken down with a different percentage depending on the payer. It is important to note this information so that you understand reimbursement is not necessarily consistent across all of your patients.

**Fee Schedule Base Year** – Each commercial contract will have a base fee schedule for reimbursement. Most often, commercial payers use a specific year of the Medicare Fee Schedule for their base, but some payers, like Aetna, will use their own fee schedule and some may reimburse based on billed charges. Make sure you know the base for your contract.

**Notes** – Keep track of when the contract became effective here. If your contract is over one year old, you will want to renegotiate. Keep track of reimbursement methodology here as well. Is this just a fee for service contract, or do you have a PMPM payment that comes with it?

*See the example in the first row of table below*:

| Payer Name | Reimbursement Rate | Fee Schedule Base | Notes |
|---|---|---|---|
| ***Ex:** ABC Insurance* | *120% HMO / 125% PPO* | *2017 Medicare Fee Schedule* | • *This contract was signed in 2017 and needs to be updated to a more current year*<br>• *This contract is a fee for service contract with different rates for HMO and PPO products* |
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**Use this table with the log from chapter one to keep track of all your commercial contracts.*



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