Draft Contracting Term Sheet

Primary Care Provider

The purpose of the worksheet is to apply what you have learned about contracting to create a mock contracting strategy for your organization. There are some terms that will not apply to your situation. For example, those listed under shared savings/risk would not apply to provider entities who are only negotiating a pay-for-performance contract. The terms in the second column are for illustrative purposes only. The user should review each and modify the strategy as appropriate to their individual circumstances.

TERM	CONTRACTING STRATEGY (sample for illustrative purposes only; modify for your organization)	TERM DOES NOT APPLY (note with an X)
Term of Agreement	Reset annually; negotiations commence at least 90 days before new year.	
	Modification mid-year only by mutual consent	
	Termination mid-year only by mutual consent except for breach of contract	
Information Exchange		
Member rosters	Delivered electronically by the first of the month	
Inpatient authorizations	Delivered daily for assigned members; include authorizations for transfer to post-acute care facilities	
Care management	Sharing of care plans of members in the health plan's high-risk care management program.	
Performance on quality metrics that have financial implication	Access to performance on the health plan's provider portal that indicates overall score and allows drilldown to the member level and benchmarked against plan wide performance; updated at least monthly.	
Total cost of care report (applies to shared savings or risk arrangements only)	Monthly report of MLR with a calculated IBNR.	
Utilization reports (applies to shared savings or risk arrangements or when one or more of these hospital utilization metrics are part of a pay-for-performance program)	Monthly report of ED utilization (separated by potentially avoidable or not), hospitalization rates, hospitalization rate for ambulatory sensitive conditions, all-cause 30-day rehospitalization rates, and benchmarked against plan wide performance.	
High-cost member list (applies to shared savings or risk arrangements only).	List of members with a rolling 12-month total cost of care of more than $100,000.	
Frequent ED utilizer list (applies to shared savings or risk	List of members with four or more ED visits in a rolling 12-month period.	

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arrangements or where ED utilization is a pay-for-performance metric only.)		
Medication possession ratios (applies to shared savings or risk arrangements or where medication adherence is a pay-for-performance metric only.)	List of members whose medication possession ratios are less than 80% for agreed upon high impact medications such as controller meds for asthma, oral hypoglycemics, psychotropic medications, statins, ACE inhibitors/ARBS.	
Raw claims data (applies to shared savings or risk arrangements only).	To be discussed in the future when LCHD able to import.	
Member Assignment	Prospective based on member choice and attribution algorithm	
	Rolling 12-month retrospective claims analysis to prospectively adjust assignment based on plurality of PCP visits with tie going to provider with latest visit.	
Payment for Direct Services	Fee-for-service at Medicaid market rates (PPS for FQHC services)	
Foundational Payments for Care Coordination	Per-member-per-month (PMPM) payment to cover these services; cost may be charged as an expense when calculating the savings pool if applicable.	
Pay for Performance		
Funding potential	1-2% of health plan premium	
Choice of metrics	Selection of 5-6 metrics from a list that is a subset of metrics which have financial implications for the health plan; may be efficiency as well as quality metrics; final metric selection by mutual agreement.	
Data collection method	Ability for provider to submit supplementary data electronically to demonstrate compliance as allowed by NCQA;	
Performance targets	Credit for significant improvement (closing gap between historical performance and attainment target) with enhanced credit for reaching the attainment target	
Payment methodology	Annual bonus when performance target is achieved	
Treatment of cost when calculating savings	Cost may not be charged as an expense when calculating savings	
Shared Savings		
Defined population	Assigned members for every month of assignment	
Minimum assigned membership	2,000	
Service exclusion	LTSS; pharmacy	

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Setting the baseline (% premium vs. historical spend)	Medical loss ratio that is a 1% improvement over historical experience but never <88%	
Risk adjusted benchmark	Yes	
Trending the benchmark	Benchmark is increased proportional to increase in plan premium	
Claims run out period/IBNR	Six months with IBNR calculation using actuarially sound principles	
Minimal savings threshold	None	
Minimal loss ratio	Ideally 2% but not if requires a symmetrical minimal savings ratio	
Risk corridor	When risk assumed, shared Losses will be limited to the lessor of reserves or 3% of the amount funding the pool multiplied by the risk share. No shared savings corridor.	
High cost claimants	$100,000-$150,000 threshold with 100% coverage of claims overage	
Shared Saving/Risk %	50-50% split; 10% of savings placed in an escrow account to build a reserve pool	
Quality gate to accessing the savings/risk pool	Ideally (but not realistically) none	
Impact of payment of savings on subsequent year's savings pool	Not charged as an expense	

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