PRC Provisional Recommendations to Date

1. AN Qualifications:

- Has the legal ability and administrative organization to contract with payers
- Responsible for the care (typically total care) of a defined population
- Is able to effectively measure the quality and efficiency of care delivery
- Coordinates clinical efforts among all participating providers (e.g. primary care, specialists, inpatient facilities)
- Will participate in Medicare programs (MSSP, Next Gen) risk criteria TBD, or similar program via Medicaid/Medicare/Commercial

Rationale:

- Include participants that are well-positioned for success
- Put sufficient pressure on total cost of care

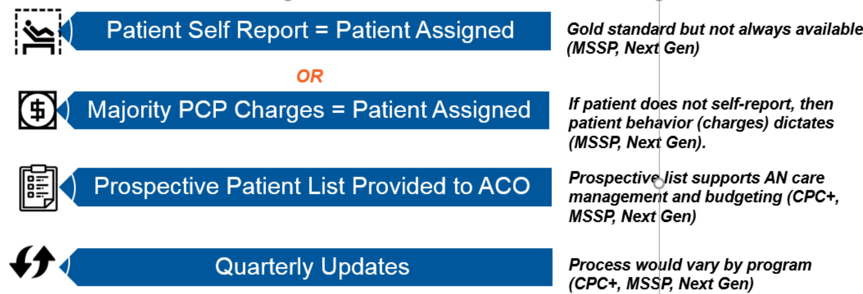
Practice (as defined by TIN) within AN:

- Providers will have a primary care specialty (family medicine, internal medicine with no subspecialty, internal medicine with a subspecialty of geriatrics, pediatrics with no subspecialty, general practice, doctor of osteopathy or nurse practitioner, or physician assistant with supervising doctor in one of the preceding specialties).
- All practices must meet core capability requirements
- Should be able to be clearly defined to ensure bundles are calculated and paid appropriately
  - Medicare: If participating in MSSP/Next Gen, needs to participate in PCM and vice versa – leverage overall contract structure
  - Other Payers: Commercial plans will leverage existing contracting structures.

Rationale:

- Ensure primary care bundle represents a meaningful portion of care provided
- Include participants that are well-positioned for success
- Limit administrative complexity.

2. Attribution:



Rationale:

- Recognize the need for consumer choice
- Leverage existing infrastructure and policies
- Give providers opportunity to know attributed patients in advance so they can outreach
- Retrospective reconciliation will not be recommended for Medicare FFS as it was determined to offer insufficient benefit for the additional effort and resource it would require.

3. Basic Bundle:

The basic bundle is a payment for a set of common primary care services, such as office visits. It will support transitioning some PCP patient care to phone, email, text or telemedicine. And, it will give the PCP greater flexibility to spend time managing care team members, participating in learning opportunities and collaborating with colleagues. There will not be any fee-for-service (FFS) payment for services included in the basic bundle for attributed patients. Providers will remain eligible for FFS payments for unattributed payments.

"Strawman" Services Included in the Basic Bundle:

Included for all Practices: Office Visit, new or established patient, Prolonged Encounter, Encounter Payment for FQHC Visit, Behavioral Health Screening, Cognition Assessment, Phone/Email/Text, Telemedicine, Home Visits (only relevant in limited circumstances and for certain populations – pediatrics, older adults and people with disabilities) and Shared Visits (optional and only applicable in some circumstances).

Not Included at this Time: Hospital, SNF Rounding, Immunization Administration, Preventive Medicine Visit, Preventive Counseling, Annual Wellness Visit

The basic bundle will be calculated using historical claims data and adjusted over time. Payers use the equation below as a framework and would determine the specific methodologies used to complete the equation.

(Base Period Claims (+/-) Addition or Deletion of Services Included) * Population Risk Adjustment * Use Trend * Unit Cost Trend (Induced Demand Factor, if needed)

Definitions below correspond to components of the equation above.

Base period claims represents a calculation of historical use of basic bundle services and price.

Addition or deletion of services included represents the value of services added or subtracted from the bundle. These could be valued based on history or expert projections (for a new service where history is not applicable).

Population risk adjustment represents the change in the risk of the population served by the bundle normalized to the overall population.

Use trend represents the projected change in primary care services for the period covered by the bundle. These projections may leverage historical changes in use, assumptions about the overall environment and assumptions about service availability.

Unit cost trend is the change in provider rates from the base period to the bundle period.

Induced demand factor is leveraged to reflect changes in coverage that impact costs (i.e. VBID).

Funds flow:

Basic bundle payments will follow current path for FFS payments.

Rationale:

- Include services that comprise meaningful portion of patient care (CPC+ as framework).
- Increase flexibility for care delivery as clinically appropriate and preferred by the patient.
- Base basic bundle on historical spend and then adjust to account for differences in patient populations and limit administrative complexity.
- Basic bundle dollars are “keep the lights on” payments for practices. PCM must ensure these funds flow appropriately and efficiently to practices. The easiest way to ensure this occurs is by having them follow the same path as today’s FFS payments.

4. Supplemental Bundle:

Supplemental bundles are payments to support activities and investments that are not normally or frequently billed as fee for service. Covers some currently billable services (ex: care management). The supplemental bundle will be based on a standardized target for all providers in a specific carrier’s program. Providers accepting greater levels of risk will be eligible for higher payments than those who do not.

Funds flow:

Supplemental bundle payments will be calculated for each Advanced Network and paid to the Advanced Network. Funds will be used to support primary care transformation and limited to the allowable uses identified by the primary care modernization design process.

Rationale:

- Introduce more equity into primary care payment
- Supplemental bundle payments will support new care team members and new technologies. Some of these investments will need to be leveraged across practices. However, there should be policies and then accountability measures in place to ensure the dollars flow to primary care to support practices in achieving the capabilities as determined during the PCM design process.

5. Provider Compensation:

Advanced networks will continue to have the ability to determine the internal compensation structure within their organizations. However, individual provider compensation will not be directly related to a provider's contribution to total cost of care in a manner that incents underservice or patient selection (i.e. cherry picking).

Rationale:

- ANs compensation structures need to fit within existing contracts, employment arrangements, organizational culture and priorities.
- There was strong support for language that prohibited ANs from structuring provider compensation in a way offered an incentive for providers to restrict access to services, not recommend care that would be helpful or select healthier patients (i.e. cherry picking).
- Still, ANs need to be able to compensate providers for providing high-quality, efficient care, which often has the impact of lowering total cost of care.