COLORADO
Department of Health Care Policy & Financing

Alternative Payment Model 2 (APM 2) Design Review Team (DRT)
Meeting 5
Meeting Minutes

Date: April 24, 2024
Time: 11:00 AM to 1:00 PM (MT)
Session Topic: APM 2 Quality Target Setting and Reward Structure

Meeting Agenda

1. Welcome and Introductions
2. Meeting 4 Recap
3. Quality Target Setting & Reward Structure
4. Looking Ahead

1. Welcome and Introductions

Suman Mathur called the meeting to order.

DRT participants in attendance were representatives of Members, providers, and other stakeholders from across the Health First Colorado landscape.

Other attendees included Araceli Santistevan (HCPF), Cordell Cossairt (HCPF), Dawson LaRance (HCPF), Ke Zhang (HCPF), Helen Desta Fraser (HCPF), Lynn Ha (HCPF), Dr. Peter Walsh (HCPF), Nicole Nyberg (HCPF), Zoe Pincus (HCPF), Gerardo Silva-Padron (Stakeholder Engagement Team), Kendra Neumann (Stakeholder Engagement Team), Suman Mathur (Stakeholder Engagement Team), Taylor Kelley (Stakeholder Engagement Team), Andy Wilson (Support Team), Chelsea Finfer (Support Team), Hayley Dennison (Support Team), Janet Milliman (Support Team) and Drew Lane (Support Team).

2. Meeting 4 Recap

Taylor Kelley recapped major discussion points from the previous meeting about attribution. Taylor Kelley presented DRT Meeting 3 Meeting Minutes for approval, and DRT participants approved.

3. Guiding Principles

Janet Milliman reiterated HCPF's North Star goal (improving the health, equity, access, affordability, and outcomes for all Coloradans) and then reminded DRT participants of the discussed goals, objectives, and measures that link to this North Star goal for APM 2. Janet discussed that each measure needs a "target" that would lead to a reward or incentive.

Janet presented the following five guiding principles for this reward structure:

- Supporting High Performance

- Making Rewards Achievable
- Scaling the Size of the Reward to Effort
- Supporting Predictability
- Drawing from Evidence-Based Observations

DRT participants were asked to share their reactions to these principles, including which guiding principles most resonated, and whether participants felt any guiding principles were missing or should be changed.

- Reactions
    - Some participants agreed that the "scaling the size of the reward to effort" principle was important for both high performers and those closer to the baseline.
    - Comment that these principles were all on track and clear at a high level but asked for more detailed components that will make up these guiding principles.
    - Some participants expressed that incentives should be attainable and consider other factors such as provider shortages in certain regions where primary care providers are also underpaid.
    - Some participants agreed that the timing of receiving a payment has made it difficult for providers to focus on their practices currently happening and should be more immediate.
    - Comment that rewards should not be solely based on claims data.

Nicole Nyberg and Helen Desta-Fraser asked participants about the ideal timeline for data and asked about the ideal frequency for providers to receive incentive payments.

- Reactions
    - Some participants noted that payment frequency depends on the purpose, that the payments needed for additional work or additional staffing, such as hiring a care coordinator, need to be made immediately, or monthly. For incentive payments, some shared that six to twelve months would be ideal, with the caveat that the longer the wait time, the less effective the incentive.
    - Comment that payments to develop an advanced primary care infrastructure would be most helpful as part of Per Member Per Month (PMPM) payments, instead of as retroactive incentive payments.
    - Some participants also expressed that stabilizing provider payments may lead to less leakage, sharing that members often switched providers because it can be difficult to find a provider who can meet their needs.

<u>Current Target Setting Methodology</u>

Zoe Pincus described HCPF's current target setting methodology, which is a "close the gap" methodology. Zoe explained that the providers' target is to improve

toward the state goal based on their own baseline performance, which means they are not measured against other providers.

Commendable Thresholds

Andy Wilson described different scenarios and discussed that reward structures can change based on how practices are performing on a specific metric. Andy provided examples of when providers do poorly on a measure (Bottom Clustering), are evenly distributed across a measure (Even Distribution), and generally do well on a measure (Top Clustering).

Andy Wilson discussed the concept of a Commendable Threshold, which is a threshold above which a practice would receive 100% of the reward.

DRT participants were invited to answer if there should be a performance level that is so good that providers should receive 100% reward. They were also asked whether this threshold should be the same as HCPF's "stretch goal," or HCPF's goal for a measure.

- Reactions
  - Participants expressed they agreed with the idea of a Commendable threshold and noted that giving 100% reward for effort would raise providers' competency.
  - One comment shared that their response would depend on how the remaining reward would be split for those who do not meet the Commendable Threshold.
  - Participants also shared that providers who do not meet metrics should still be rewarded, suggesting giving a 100% reward to those who meet the Commendable Threshold as well as providing a 100% reward to those who close the gap or increase their performance.

Andy Wilson asked DRT participants about whether the Commendable Threshold should change depending on current practices' performance.

- Reactions
  - A participant mentioned that providers hitting the threshold should receive the full reward and that, in other cases, it may make sense to make rewards specific for individual providers and regions.
  - One participant suggested providing incentive payment to a practice that makes a significant improvement but does not reach a Commendable Threshold and then maintains that improvement.
  - Participants also noted that allowing providers to participate in different tiers that tie to different expectations and payments could be helpful to tie payments to providers' capacity.
  - Participants wondered whether the size of practice and other factors would be a consideration for these thresholds.

Minimum Acceptable Thresholds

Andy Wilson discussed the idea of a Minimum Acceptable Threshold. This is a level of performance that is so low that there should be no reward for falling below it.

Taylor Kelley facilitated a conversation surrounding Minimum Acceptable Thresholds and asked DRT participants if there should be a performance level that is too poor below which no reward should be given.

- Reactions
  - Comment that it would be helpful to understand how much money the incentive is compared to the standard PMPM for attributed patients.
  - Some participants suggested that it may be useful to split rewards based on tiers, and those below some minimum level should receive a one-year grace period to help with performance.
  - Some participants added that low performing providers could have structural incentives to help them overcome barriers to improving.
    - HCPF noted that this has been a discussion topic and that they are thinking about informational measures that can help ensure program success.

Rewarding Between Commendable and Minimum Acceptable Threshold

Andy Wilson discussed two considerations for partial reward between the Commendable and Minimum Acceptable Thresholds.

Helen Desta-Fraser asked DRT participants whether it makes more sense to continue using HCPF's current "close the gap" methodology, or whether it is better to use a simpler approach that looks at percentile improvement and national benchmarks.

- Reactions
  - Some participants highlighted that effort should take into consideration patient refusal or noncompliance.
  - Comment that they also liked the idea of using tiers but noted that these tiers would need to consider practices' willingness to serve Members with complex health needs.

Dr. Pete Walsh shared that HCPF is thinking about moving away from raw performance numbers and toward percentiles to simplify the methodology.

- Reactions
  - Some participants shared that tiering or having points between a Minimum Acceptable Threshold and a Commendable Threshold, may make more sense than using a "close the gap" approach.

4. Looking Ahead

Gerardo Silva-Padron shared that the next DRT session will be Wednesday, May 8 from 11:00 a.m. to 1:00 p.m., and that it will focus on payment. Suman Mathur added that the APM 2 DRT will be using the July 10, 2024, calendar hold for a DRT session.