COLORADO
Department of Health Care Policy & Financing

Alternative Payment Model 2 (APM 2) Design Review Team (DRT)
Meeting 10
Meeting Minutes

Date: July 10th, 2024
Time: 11:00 AM to 1:00 PM (MT)
Session Topic: APM 2 Payment -Joint Accountability and Care Coordination

Meeting Agenda

1. Welcome and Introductions
2. Meeting 9 Recap
3. Primary Care Activities Not Currently Reimbursed Under Fee-For-Service (FFS)
4. Looking Ahead

1. Welcome and Introductions

Taylor Kelley 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), Britta Fuglevand (HCPF), Christine Kim (Support Team), Dawson LaRance (HCPF), Zoe Pincus (HCPF), Gerardo Silva-Padron (Stakeholder Engagement Team), Suman Mathur (Stakeholder Engagement Team), Taylor Kelley (Stakeholder Engagement Team), Andy Wilson (Support Team), Chelsea Finfer (Support Team), Christine Kim (Support Team), and Janet Milliman (Support Team).

2. Meeting 9 Recap

Taylor Kelley recapped major discussion points from the previous DRT meeting 9 about program sustainability considerations for practices that work with specific populations.

3. Primary Care Activities Not Currently Reimbursed Under Fee-For-Service (FFS)

Janet Milliman opened the conversation with some level-setting, describing that the focus of today's conversation is to think about primary care activities that are not traditionally reimbursed under fee-for-service.

Janet Milliman walked through a list of primary care activities that are not currently reimbursed under Fee-For-Service. Janet explained that categories of activities were adapted from the DOI Regulation Concerning Primary Care Alternative Payment Model Parameters to help better organize and discuss these activities and to fit the context of primary care.

Reactions:

- One participant asked about services that do have well defined CPT codes, but Medicaid does not cover them.

- Janet clarified that the expansion of Medicaid covered CPT codes was not in the scope of the current conversation since the focus is not on expanding the benefits of Medicaid.

Team-Based Care

Janet Milliman introduced the concept and activities under Team-Based Care, including integrated behavioral health, health coaches and navigators, community health workers, and recall systems for service reminders.

Reactions:

- One participant highlighted that integrated and coordinated care are not covered by Medicaid.
- Participants mentioned that in urban and, mostly in more rural areas, PCMPs are providing integrated care more, due to patients' lack of access and technology. Rural and small practices do not have the staffing nor financial ability to hire behavioral health professionals, however we see the PCPs providing more integrated care services.
- Participants mentioned that care coordination doesn't have reasonable reimbursement such as connecting patients with specialists.
- One participant said patients with complex disabilities may not be getting much team-based care due to inequitable access and lack of provider ability to serve complex patient populations, due to lack of adequate resources to provide necessary complex care services.

Integrated Behavioral Health (BH)

Janet Milliman provided a deeper dive of Integrated Behavioral Health (BH). Janet highlighted some foundational, enhanced, and advanced practice activities related to integrated behavioral care.

HCPF added that they would like to understand the scope of everything else that happens in primary care practices with regards to provision of behavioral health services. HCPF would like to know how the integrated care continuum of care resonates, what is missing, and how what has been presented aligns with experience in providing and receiving primary care.

Reactions:

- Some participants noted some providers may never be able to get to the advanced level, given their size and workforce constraints and suggested that tying their performance to a value-based payment (VBP) model might be inequitable.

- Participants mentioned there has been a significant amount of upfront expenses for things like training, onboarding, planning, etc., which has been part of the 1302 discussions. The participant asked about the nexus between that discussion and the upfront cost for initiating and then ongoing cost once a model is in place.

- One participant added that there is a lot of variation in terms of how integrated care is integrated. Noting that some practices have more of a collaborative care model that involves a consultative model with a psychiatrist. This model is more diagnosis focused, rather than a therapist that is taking more of a generalist approach, suggesting there is more nuance than what is captured here.

- Participants added that in rural areas, it is so much more difficult to attract behavioral health professionals, and Medicaid needs to recognize that a huge chunk of the state and the beneficiaries are in rural areas. The pay needs to be exceptional to hire behavioral health staff in rural areas.

- Some participants said they liked the levels of integration and said that depending on the opportunity for financial incentives/support, this model could be achievable.

- One participant noted that their practice is facing a challenge where they must have an identified behavioral health provider (BHP) in order to have contracts and credentialing in place. The participant said that the providers must be flexible on a relationship basis to stand in until they are officially approved to start seeing patients.

- Participants also added that referrals (noted under advanced) and appointment availability are very difficult to track.

Member Engagement

Janet Milliman presented the list of activities that fall under Member Engagement. Janet highlighted that one engagement activity was health related social needs screening and assistance connecting members/families to resources. In addition, Janet mentioned health prevention education and counseling, member outreach and follow-up, and lastly, gathering patient feedback were all examples of member engagement.

Reactions:

- Participants shared that some services are not reimbursed well, and that there should be inclusion and recognition of provider-patient communication that happens outside of a visit that doesn't get reimbursed.

- One participant added that patient portals have added extra work and tons of administrative work is not reimbursed, such as filling out paperwork for patients, prescription refill requests and record reviews.

- One participant encouraged Medicaid to rethink the documents that physicians must complete, because they take a lot of time that physicians don't get paid for. They added that ASL interpretation is not being covered either.

- One participant also added some examples of member engagement activities that are not reimbursed include: annual well-visit reminders (that require multiple attempts) and urgent care/emergency department/hospital follow-up.

Health Related Social Needs (HRSN) Screening and Assistance

Janet introduced the topic of HRSN screening and assistance by sharing various levels derived from the Massachusetts Primary Care Sub-Capitation Program. Foundational support includes activities such as social screenings and assessments with resource inventory, enhanced includes support with public assistance applications, and the advanced level includes a dedicated staff member that directly facilitates Member connection with community resources.

Reactions:

- One participant added that understanding the relationship between APM 2 and what is outlined in the ACC Phase III RFP is important and noted that this seems duplicative between what RAEs are being asked to do, and what providers are being asked to do via APM 2.

- One participant added that tying increased HCPF investment to higher tiers of care capacities in the PMPM can provide more stability, predictability, and flexibility via shared savings.

- One participant added that to be successful in HRSN, you need to be at the advanced level to truly address patients' needs. The participant also said that maintaining and updating resource lists for patients is necessary, and patients often need assistance reaching out to these resources, underscoring the need for dedicated staff.

- Participants agreed that health navigator support is needed to make the social screening activities meaningful, otherwise there is a risk of just having a checkbox activity that is not valuable to Members.

- One participant suggested leveraging existing resources like Family Resource Centers with dedicated specialists that do the work to connect people to resources. The participant proposed making it easier for PCMPs to access these existing resources, which would be more efficient and beneficial for patients, reducing additional expense and effort within the primary care space.

Access

Janet Milliman introduced the domain of "access," explaining that this could mean office hour triage, same day appointment availability, extended hours and physical spaces/services that are accessible and responsive to patient needs.

Reactions:

- One participant mentioned that some practices provide weekend clinics for vaccinations like COVID or flu where they would have extra hours to work.
- Participants mentioned that for space and equipment needs, there will have to be a separate allocation of funding into primary care. Participants highlighted that ongoing services, increased hours, and time for paperwork need to be part of the APM 2 payment, while the equipment funding should come from somewhere else since one leads to the other.
- One participant mentioned that it is not just provider time or staff time for access but also technology (i.e. HIPAA secure messaging and answering services) that needs to be funded.

Physical Spaces and Services Accessible and Responsive to Patient Needs

Janet Milliman provided a deeper dive into Physical Spaces and Services Accessible and Responsive to Patient Needs and how that looks for accessibility efforts. Janet walked through all the foundational, enhanced, and advanced activities that can be recognized in accessible and responsive services to patient needs.

Reactions:

- One participant shared that public transportation and safety concerns are important for accessibility challenges.
- Participants encouraged infrastructure funding for certain equipment to help support the ongoing care to serve this population. One participant commented that there's a parallel to what we talked about with behavioral health integration and other aspects of advanced primary care — that there are often significant upfront infrastructure and initial transformation one-time costs that need to be supported in addition to the ongoing costs.

Care Coordination

Janet Milliman introduced the final topic of discussion about care coordination, including activities such as referral tracking and monitoring, and coordinating transitions of care. She shared an example derived from the Colorado State Innovation Model (SIM) which has three levels: foundational, enhanced, and advanced. At the foundational level, a practice employs

a care coordinator to facilitate communication among care providers and health education, while the enhanced level performs proactive outreach and bi-directional communication with other practices. The advanced level performs the other levels but also includes communication with other practices and community organizations (schools, housing, criminal justice systems, etc.).

Participants were asked to provide feedback on care coordination for primary care practices.

Reactions:

- One Participant asked for clarification on where the care coordination lines are between the RAEs and the provider because it is confusing to the patient to know who is responsible for what.
    - Janet explained that the RAEs can subcontract with providers who have the ability to do care coordination and will pay a higher PMPM payment for that work. If the provider does not receive an additional PMPM, it is the responsibility of the RAE to do that care coordination and employ teams that are available at different levels, like social workers or nurses.
- One participant shared that there is a lot of care coordination between agencies for criminal justice involved clients or those with a substance use disorder.
- Participants suggested that HCPF reconsider what qualifies for offering "extended hours," since this requires more staff time beyond the provider, which must be factored in by the clinic/entity if they offered extended hours. Some suggested that anything before 9am and after 5pm, Monday through Friday, should be considered extended.

4. Looking Ahead

Gerardo Silva-Padron closed the DRT session by thanking participants and noted the next meeting will be July 24 from 11:00 a.m. to 1:00 p.m.