COLORADO
Department of Health Care Policy & Financing

Alternative Payment Model 2 (APM 2) Design Review Team (DRT)
Meeting 8
Meeting Minutes

Date: June 12, 2024
Time: 11:00 AM to 1:00 PM (MT)
Session Topic: APM 2 Cost Target Setting and Payment Methodology

Meeting Agenda

1. Welcome and Introductions
2. Meeting 7 Recap
3. Prospective Payment and Reconciliation
4. Incentive Payments
5. 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), Dawson LaRance (HCPF), Ke Zhang (HCPF), Zoe Pincus (HCPF), Nicole Nyberg (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), Janet Milliman (Support Team) and Drew Lane (Support Team).

2. Meeting 7 Recap

Taylor Kelley recapped major discussion points from the previous DRT meeting 7 surrounding Tiering and Sliding Scale reward options.

3. Prospective Payment and Reconciliation

Janet Milliman shared the payment design components in relation to primary care services and shared savings payments: APM2 Core Services, Quality Payment, and Chronic Condition Shared Savings Payment. Janet focused the conversation on the APM2 Core Services component and talked through how current participation works for primary care payments.

She explained that PCMPs can participate in a blended model between fee-for-service (FFS)

and prospective payment. Janet walked through an example scenario in which a PCMP may receive more payment through prospective payment than they would have compared to FFS rates, and vice versa.

Reactions:

- Participants asked if PCMPs were locked into their decision for prospective payment or if they have the flexibility to determine their options.
- Participants asked how often the prospective payment would be recalculated and if reconciliation will be factored in.
- One participant asked if special populations, specifically children, would be factored into prospective payments and if there would be an incentive for serving this population.

DRT participants were asked to share in what scenarios prospective payments make sense and to identify unintended consequences of prospective payments. They were also asked the following questions:

- In what scenario would prospective payment make sense?
- What are the unintended consequences of a prospective payment?
    - How could those consequences be mitigated?
- Should risk relative to FFS rates be limited?
    - Should there be a two-sided risk corridor for potential gain/loss?
    - Should risk thresholds be equal between the provider and department?

Reactions:

- Participants suggested that unintended consequences, like those seen during the pandemic, can significantly impact utilization and access. For small practices, losing a provider could severely reduce access to care, potentially leading to overpayment in prospective payment models or issues with the split of funds.
- Participants raised concerns about an overpayment of prospective payments and how it might be detrimental to a practice if they have to pay it back.
- Participants mentioned unintended consequences of payment models, such as reduced access to care and challenges for small practices.
- Participants expressed concerns of payment models tied to volume, highlighting their limitations in promoting team-based care and adequately compensating certain healthcare professionals.

- One participant stressed how shifting to a prospective payment structure will call for better management of patient visit volumes and shadow-billing to avoid a cliff effect in future rate periods.
- One participant highlighted the importance of revenue stability in prospective payment models, alongside the flexibility to adapt care delivery and cover services not well addressed under fee-for-service models.
- One participant shared integrating whole person care principles into payment models and ensuring recognition of diverse healthcare needs.
- Participants stressed that it is essential to have guard rails when it came to repayment to protect practices for their visit volumes.
- One participant raised concerns regarding transparency and understanding of adjustments for patient leakage in prospective payment system.

4. Incentive Payments

Janet Milliman discussed incentive payments and provided the DRT participants with an example scorecard scenario. Janet Milliman walked through how incentives might be paid out in relation to quality.

Taylor Kelley opened the discussion up to the participants to discuss how incentive payments should be distributed as well as the timing of payment for quality performance. Taylor asked the following questions to the DRT participants:

- What are implications of incentive payments being distributed through a PMPM as opposed to a lump sum?
    - E.g. timing, complexity, administrative burden, etc.
    - How might this impact patient experience?
- How often should provider-level performance be calculated?
    - In the case of a lump sum payment, how often should payment be distributed?
    - How often should the PMPM be adjusted?

Reactions:

- Participants suggested that lump sum payments might be helpful for providers who do not have robust accounting or administrative staff to help with the process.
- One participant suggested lump sum payments should be quarterly since any longer duration would not be helpful for practices when considering budgeting or reliability.

- One participant shared that lump sum payments can be less predictable, and a monthly payment can meet the payroll needs of practices.
    - One participant expressed that monthly payments require attention to attribution which can be a benefit.
- One participant shared that delay of payment can be an issue for providers as they are making decisions such as investing in new staff or technology.

Andy Wilson shifted the conversation to Chronic Condition Shared Savings and explained how it works in the current program.

Participants were asked to provide feedback on the following questions:

- Should the provider's portion of shared savings be adjusted from the current share of 50%?
    - What other stakeholders are involved in generating savings (e.g., RAEs)?
    - What patient and provider behaviors result in savings being generated (e.g., care coordination)?
- Is a commendable threshold of 2% cost savings still appropriate?

Reactions:

- One participant shared that changing the share of 50% more towards the provider can be more incentivizing, suggesting a 60% provider split. The participant highlighted the importance of this approach in promoting cost-effective practices, citing examples such as care coordination, integrated behavioral health services, medical assistants, front desk support, and resources addressing social determinants of health. They emphasized that expanding the scope of services offered by primary care facilities can lead to significant cost savings, emphasizing the critical need for adequate funding to hire and sustain essential staff members.
- One participant shared they do not have an issue with the 2% cost savings but recommended rewarding all shared savings above the minimum acceptable threshold as a victory.
- One participant expressed optimizing incentive structures to better reward providers, such as adjusting the distribution of savings between providers and the state and considering the broader impact of primary care services.
- One participant stressed the need for aligning data with diagnosis or disabilities to better understand the providers supporting patients with special health care needs.

- Participants shared the importance of incentivizing specialty care providers within shared savings programs to encourage holistic care delivery.
- Participants acknowledged the challenges providers face in delivering comprehensive care to diverse patient populations, including concerns about training and resources.
- Participants raised concerns about the inclusion of individuals with complex conditions in payment models and the need for providers to address diverse patient needs effectively.
- Participants discussed the balance between incentivizing providers and managing program risks, particularly in shared savings models.

5. Looking Ahead

Gerardo Silva-Padron shared that the next DRT session will be Wednesday, June 26thth from 11:00 am – 1:00 pm.