COLORADO
Department of Health Care Policy & Financing

Alternative Payment Model 2 (APM 2) Design Review Team (DRT)
Meeting 9
Meeting Minutes

Date: June 26, 2024
Time: 11:00 AM to 1:00 PM (MT)
Session Topic: APM 2 Program Sustainability

Meeting Agenda

1. Welcome and Introductions
2. Meeting 8 Recap
3. Considerations for Varying Provider and Population Types
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), 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), Janet Milliman (Support Team) and Drew Lane (Support Team).

2. Meeting 8 Recap

Taylor Kelley recapped major discussion points from the previous DRT meeting 8 about payment design components for primary care services and incentive payments for quality metrics and chronic condition shared savings.

3. Considerations for Varying Provider and Population Types

Araceli Santistevan introduced framing for the discussion by asking participants to think about complicating variables that may prevent or limit a Primary Care Medical Provider (PCMP) from participating and succeeding in a VBP model or limit a PCMP's ability to provide high-quality care. She asked participants to share their expertise in identifying these issues and their impact on provider and member experience, outside the parameters of an Alternative Payment Model (APM). Araceli shared an overview of the risk

adjustment variables that the Chronic Condition Shared Savings programs currently adjusts for. She acknowledged that these criteria do not encompass all complicating factors.

Araceli then shared considerations stakeholders have previously suggested the Department incorporate in future APM 2 design. This included the additional pressures faced by rural providers, small practices, pediatric practices, and practices that serve populations with medical and/or social complexity. She noted that these are not mutually exclusive and shared that Federally Qualified Health Centers (FQHCs), School Based Health Centers (SBHCs), and Rural Health Clinics (RHCs) can fit into any of these models.

Rural Practices

Janet Milliman presented the definition of rural practices — practices that operate in areas with a total geographic population lower than 200,000 and where the population density is below 100 people per square mile. She then presented the financial barriers of these populations, many of which relate back to unpredictable cash flow and the additional burden on PCMPs to coordinate care given the lack of specialty care providers in these areas. Janet then explained how this impacts PCMP experience and member experience.

Participants were asked to share feedback on other factors that make rural practices unique,

what ideas they may have for model design consideration when thinking about rural practices, and what resources and support rural practices may need to be successful in an APM.

Reactions:

- Participants suggested that there are other issues patients experience in rural area such as: Limited specialist access and transportation issues due to long driving distances; Impact of seasonal factors like harvest season on patient access to care; weather conditions affecting accessibility, especially in mountainous regions; and equipment limitations and perceptions affecting service availability.
- Participants raised discussions for development of financial buffers and reimbursement models to support home-based healthcare services.
- Participants mentioned better reimbursement efforts/incentives for providers that provide culturally competent care. One participant

mentioned how language translation is important for agricultural settings.
- Participants talked about the shortage of healthcare workforce due to lack of population growth and retention challenges.
- One participant stressed that income and health literacy can be a barrier for rural communities suggesting some patients are unaware of the care in the area or not willing to access the care, especially behavioral health services. They also cited limited access to telehealth and IT infrastructure.

Small Practices

Janet Milliman shared the challenges faced by small practices (defined as less than five providers), including the fact that many small practices may not have enough attributed Medicaid members (30 members) to qualify for certain quality incentive measures, and miss out on these payments. They also may struggle with high fixed costs for infrastructure, capital, and other expenses. Janet explained how these challenges may impact PCMP experience and member experience.

Participants were asked to share feedback on other factors that make small practices unique, what ideas they may have for model design consideration when thinking about small practices, and what resources and support small practices may need to be successful in an Alternative Payment Model (APM).

Reactions:

- One participant commented that recruiting and retaining staff are challenges due to not being able to match larger practice salaries and benefits.
- One participant mentioned how aggregating data with an entity allowed for the provider to meet the metrics in service for the population the small practice was supporting.
- Participants expressed how small practices with small numbers of providers struggle to meet the quality metric goals, specifically when patients don't comply to meet the quality metric goals or have been geographically attributed to the practice but do not have a relationship with the provider.
- Participants commented that small practices focus on care delivery and do not have the infrastructure, data management resources, or staff to perform panel management work.
    - One participant expressed streamlining and simplifying documentation and reporting requirements would be helpful to

support small practices so that they can focus on enhancing patient outcomes.

Pediatric Populations

Janet Milliman began the conversation on population types with providers who serve pediatric populations. Janet discussed the financial barriers for providers that serve the pediatric population, including that half of children are covered by Medicaid, leading to a high Medicaid payer mix, which is historically underfunded. She also highlighted the high cost and small panel size due to frequency of preventive and sick visits as another financial barrier. Janet shared how these barriers impact the PCMP and member experience, citing workforce issues, increased financial risk, limited access to care and reduced provider choices, and limited access to patient-focused activities such as education and care coordination.

Participants were asked to share feedback on other factors that make pediatric populations unique, what ideas they have for model design consideration when thinking about pediatric populations, and what resources and support could be provided to pediatric practices so they can be successful in an Alternative Payment Model.

Reactions:

- One participant noted that pediatric practices serving youth with special health care needs face difficulty in finding family medicine practices to transition these youth to as they grow older, often continuing to care for them into their 20s.
- One participant expressed that practices shouldn't be financially penalized in terms of low patient volumes due to taking on more complex pediatric patients, since they might take on fewer patients that require time-intensive support.
- One participant stressed how difficult it is to apply any shared savings concepts for youth since the "return of investment" on prevention with kids takes a longer time to materialize.
- Participants shared the differentiation of adults with disabilities versus children with disabilities, suggesting more intentional support from the Department and incentives for practices to use resources and participate in trainings.

Populations with Complex Medical and Social Needs

Janet Milliman introduced the topic about practices that serve members with complex medical needs. She said billing does not account for extra time needed for patients with complex needs and that there needs to be additional infrastructure that is accessible at facilities with financial barriers. Janet also discussed the costs of training for providers and how recruitment and salaries for staff with specialized experience can be a challenge. She then talked about implications on the PCMP and member experience, sharing that necessary staff training is lacking, more care coordination is needed, and member access is limited.

Participants were asked to share feedback on other factors that make medically complex populations unique, what ideas they have for model design consideration when thinking about medically complex populations, and what resources and support could be provided to practices so they can be successful in an APM.

Reactions:

- Participants emphasized that medical and social complexity often overlap and should not be treated separately. The participant pointed out that both populations face similar barriers and challenges, regardless of the specific source of their complexity.

Janet Milliman introduced the topic of practices that serve members with complex social needs. She shared that one financial barrier is non-reimbursed time spent on health-related social needs coordination and multi-system case management. She also said language interpretation and services and patient leakage are financial barriers. Janet acknowledged how these financial barriers have an impact on the experience of the practice and patient. This could result in fewer patients seen per day because of longer appointment times and increased reliance on care coordination. She talked about the increased need for behavioral health support for members with mental health conditions and substance use disorders. Janet highlighted that patient-centered care may be limited if staff are under-resourced or have limited capacity to address complex social needs. In addition, Janet mentioned the limited access to telehealth or online platforms and the long waits for appointments with specialists or highly experienced providers.

Participants were asked to share feedback on other factors that make medically and socially complex populations unique, what ideas they have for model design consideration when thinking about these populations, and

what resources and support could be provided to practices so they can be successful in an Alternative Payment Model.

Reactions:

- Participants expressed how patients with complex medical needs, including older adults, face a heavy burden navigating multiple specialties, arranging transportation to different offices, and undergoing various tests.
- One participant emphasized the importance of including immigrants, refugees, and asylees in healthcare definitions. The participant recognized the complexity of capturing the diverse needs of these groups.
    - Participants highlighted the substantial financial challenges experienced by providers serving these populations, noting that not all individuals in these groups are eligible for Medicaid coverage.
    - One participant expressed how there is often a cultural fear of the healthcare system among these populations, which can lead to hesitancy and distrust in accessing care.
- One participant shared said that non-reimbursed time is a significant barrier for complex members, but emphasized that even for reimbursed services, providers are not reimbursed adequately.
- One participant suggested that the current risk adjustment methodology in APM 2 lacks transparency because it is not open-source and that there should be visibility and accessibility for all stakeholders.
- Participants emphasized the necessity of incentives for providers, particularly in smaller practices, to ensure access to services for medically and socially complex populations.
- Participants stressed the need for support in care coordination and other services, advocating for changes to remove financial barriers hindering care provision.

4. Looking Ahead

Gerardo Silva-Padron closed the DRT session by thanking participants and noted the next meeting will be July 10 from 11:00 a.m. to 1:00 p.m.