**Alternative Payment Model 2 (APM 2) Design Review Team (DRT)
Meeting 3 Minutes**

Date: March 13, 2024
Time: 11:00 AM to 1:00 PM (MT)
Session Topic: Quality Measure Selection

Meeting Agenda

1. Welcome and Introductions
2. Meeting 2 Recap
3. Future State Measures
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), Helen Desta Fraser (HCPF), Michael Whitman (HCPF), Nicole Nyberg (HCPF), Pete Walsh (HCPF), Breelyn Brigola (Stakeholder Engagement Team), Kendra Neumann (Stakeholder Engagement Team), Moriah Bell (Stakeholder Engagement Team), Suman Mathur (Stakeholder Engagement Team), Andy Wilson (Support Team), Chelsea Finfer (Support Team), Hayley Dennison (Support Team), and Shani Ogilvie (Support Team).

2. Meeting 2 Recap

Suman Mathur presented DRT Meeting 2 Meeting Minutes for approval, and DRT participants approved.

3. Future State Measures

Dawson LaRance shared background about how the APM 1 program measures provider performance and talked about how measures will be used in the future APM 2 program. Araceli Santistevan shared updates about the future of APM 2, specifically noting that APM 1 will be sunset and that there will be a single quality model as part of the APM 2 redesign.

Suman Mathur shared several considerations that HCPF is using to select measures for APM 2. She described how measures should 1) align with industry standards and other programs, 2) link back to APM 2 program goals, and 3) be statistically reliable and valid.

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Dr. Peter Walsh, Chief Medical Officer at HCPF, presented information on other programs that use the quality measures that the PACK program will be aligned with, including the Division of Insurance (DOI) Regulation 4-2-96 Pediatric Measure Set, core measures released by the Centers for Medicare and Medicaid Services (CMS), the Department's Health Equity Plan, key performance indicators for Phase III of the Accountable Care Collaborative, and CMS Innovation Model (CMMI) Making Care Primary (MCP). Tara Smith, from the Division of Insurance (DOI), described the DOI stakeholder engagement process for choosing measures and shared the DOI's list of measures for adult primary care.

HCPF remains committed to using the seven measures in the DOI Adult Measure Set, which contains six clinical measures and one patient experience measure:

- Breast Cancer Screening
- Cervical Cancer Screening
- Colorectal Cancer Screening
- Screening for Depression and Follow-Up
- Comprehensive Diabetes Care
- Controlling High Blood Pressure
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Adult Survey or Person-Centered Primary Care Measure (PRO-PM)

Hayley Dennison discussed the importance of tying the program measures directly to the program goals and objectives.

DRT participants were given the opportunity to share feedback or questions about these measures.

- DRT participants shared the following considerations for these measures:
  - Comments that the Person-Centered Primary Care Measure intentionally uses "doctor" to refer to any type of provider, to reflect how patients think about health care.
  - Comment that CAHPS is administratively burdensome and that it may be useful to look for a less burdensome tool to collect Member experience.
  - Comment that the screening measures tend to be less relevant for Members with disabilities, who often face barriers when trying to schedule and complete annual physicals.

DRT participants were then asked to think about other measures outside of this list that may be useful to track for program evaluation and provider performance improvement purposes. This discussion was based around program goals and associated objectives.

- Goal 1: Reduce avoidable hospital use for Members and increase use of primary care services.
    - Objective: Reduce avoidable emergency department utilization and hospital admissions for Members with chronic conditions.
    - Objective: Increase utilization of preventative care appointments.
- DRT participants suggested the following considerations for measures associated with Goal 1:
    - Addition of a measure that focuses on substance use.
    - Suggestion to look at the barriers that Members face when trying to access primary care and measure strategies to mitigate those barriers.
    - Definition of "avoidable care" within the first objective.
    - Focus on stratifying data from measures by population, such as by race/ethnicity.

- Goal 2: Improve clinical outcomes for Members with chronic conditions.
    - Objectives: TBD.
- DRT participants suggested the following considerations for measures associated with Goal 2:
    - Addition of a behavioral health condition as one of the chronic conditions.
    - Focus on both care coordination and prevention as ways to improve clinical outcomes for these Members.

- Goal 3: Close the gap in disparities for primary care outcomes across the state.
    - Objective: Increase sharing of stratified data to understand current disparities and target areas for improvement.
    - Objective: Improve the use of culturally competent care approaches.
- DRT participants suggested the following considerations for measures associated with Goal 3:
    - Discussion of whether culturally competent care is better measured using number of trainings completed or using surveys about Member experience. Suggestion that HCPF strive to measure patient experience of culturally competent care, if possible.
    - Comment that measure should look at disparities across racial, geographic, or other demographic groups for specific health outcomes.
    - Addition of measure of whether practices provide accessible and culturally competent services, such as the presence of accessible equipment, offers of language services, and collection of pronouns and other background information.
    - Comments that cultural competence trainings vary in quality and can be time-consuming, and suggestion that HCPF should focus on high-quality trainings.

- Goal 4: Close the gap in rural vs. urban disparities for primary care outcomes across the state.
    - Objectives: TBD.

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- DRT participants did not have any additional considerations for measures associated with Goal 4.

- Goal 5: Reduce total costs of care while keeping primary care costs per Member stable or higher.
    - Objective: Provide resources to support practice transformation to facilitate appropriate, timely utilization of support resources and programs.
    - Objective: Reward primary care practices that demonstrate high-quality care.
    - Objective: Keep total cost of care spend equal or lower than current levels.
- DRT participants suggested the following considerations for measures associated with Goal 5:
    - Focus on how practices use remote patient monitoring and technology to drive accountability.
    - Support for practices who need to update their electronic medical records in order to meet these objectives.
    - Recommendation to tie measures to whether practices would be considered "advanced primary care," with specific examples of "advanced primary care" including things like integrated behavioral health care and team-based care.
    - Concerns that high-quality care could be subjective and suggestions to define this more clearly before creating measures.

- Goal 6: Provide stabilized revenue and upfront investment into primary care practices.
    - Objective: Assess revenue streams for consistency and best practice approaches.
- DRT participants suggested the following considerations for measures associated with Goal 6:
    - Focus on greater funding for preventative care and on reducing downstream costs.

4. Looking Ahead

Next DRT Session: Wednesday, March 27th from 11:00 AM-1:00PM (MT)
Meeting Topic: Attribution
Resources:
- [APM 2 Program Resources](#)
- APM 101 Videos:
- [APM 1](#)
- [APM 2](#)

Questions can be sent to [HCPF_VBPStakeholderEngagement@state.co.us.](#)

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