COLORADO
Department of Health Care Policy & Financing

Alternative Payment Model 2 (APM 2) Design Review Team (DRT)
Meeting 4
Meeting Minutes

Date: March 27, 2024
Time: 11:00 AM to 12:30 PM (MT)
Session Topic: APM 2 and Accountable Care Collaborative (ACC) Phase III Attribution Methodology

Meeting Agenda

1. Welcome and Introductions
2. Meeting 3 Recap
3. Attribution
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), Matt Lanphier (HCPF), Michael Whitman (HCPF), Breelyn Brigola (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), and Shani Ogilvie (Support Team).

2. Meeting 3 Recap

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

3. Attribution

Suman Mathur provided background information on the Accountable Care Collaborative (ACC). Phase III of the ACC will begin in July 2025.

Matt Lanphier provided background on what attribution is and why attribution is important. Attribution is how Health First Colorado members are linked to a Primary Care Medical Provider (PCMP). Matt discussed the four methods of attribution in the current system, ACC Phase II. These are utilization, family connection, geographic, and member choice.

Matt Lanphier talked about changes between attribution in Phase II and Phase III, which have happened largely in response to stakeholder feedback. Matt

discussed the decision to eliminate geographic attribution and attribution based on family connection.

DRT participants were given the opportunity to ask questions about the changes to attribution methodology.

- DRT participants asked questions that led to the following clarifications:
  - Attribution occurs at the practice level, which means that reattribution is not necessary if a Member switches providers within a practice.
  - RAEs will continue to receive rosters of Members, and this will indicate Members not attributed to any practice.
  - Reattribution will occur monthly for unattributed Members and quarterly for attributed Members.
  - Family attribution for siblings will no longer occur.
  - Claims-based attribution for adults will use all Evaluation and Management codes.

DRT participants were also given the opportunity to share considerations for this attribution methodology, particularly as it relates to APM 2.

- DRT participants shared the following considerations to refine the attribution methodology, particularly as it relates to APM 2:
  - Some participants appreciated that Member choice is prioritized above other forms of attribution. Others cautioned that, if Members forget they have chosen a provider and switch providers, it can be very difficult for practices to receive administrative funding.
  - Some participants suggested including population-specific pieces in attribution methodology, such as attribution of Members with special social or health care needs to providers with specific disability or cultural competencies, when relevant.
  - Participants suggested refinements to this approach, so Members are not accidentally attributed to primary care medical providers who also provide limited specialist services, such as pain management or recuperative care.
  - Some participants suggested that claims-based attribution for adults be based solely on preventive Evaluation and Management codes, while others felt that this could create problems, particularly when serving populations who seek less preventive care.
  - Some participants suggested re-adding family attribution for siblings who may be attributed to the same pediatric practice.
  - A few participants were concerned that more frequent reattribution could undermine payment stability in APM 2 and suggested thinking about solutions to regulate attribution fluctuations to stabilize payments.
  - Participants suggested that there be a way for providers to reconcile attribution lists when there are errors on that list.

- A few participants noted that, with the removal of geographic attribution, small practices may not be able to participate in APM 2 and suggested that HCPF think about how to support these practices so they can continue to participate.

4. Next Steps

Suman Mathur provided a list of resources and reminded participants about the next meeting about Quality Measure Target Setting on April 24th from 11:00 am – 1:00 pm (MT). Suman then closed the meeting.