COLORADO
Department of Health Care Policy & Financing

APM 2 Design Review Team: Session 2

February 28, 2024

Agenda

1. Welcome and Introductions
2. Meeting 1 Recap
3. Current State of APM 1 and APM 2
4. Goals, Objectives, and Measurable Outcomes
5. Looking Ahead
6. Appendix

1. Welcome and Introductions

Meet the APM 2 Team

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2. Meeting 1 Recap

The Purpose of the Design Review Team (DRT)

To inform the redesign of the Alternative Payment Model for primary care (APM 2).

In Scope	Out of Scope
• **Communicate insights, experience, and expertise** on the topics presented • **Make suggestions or propose ideas** for the redesign of APM 2 within the context of the topics presented • **Provide feedback** to any consideration or option put forward for the redesign of APM 2 • **Ask questions!**	• Make final decisions on the redesign of the APM 2 program • Provide formal recommendations (i.e., report or standard documentation) • Discuss recommendations on design elements that cannot be changed (these elements will be communicated during relevant DRT sessions)

The Design Review Team will provide iterative feedback to HCPF on key design topics

1. **Goals and Objectives:** What are we trying to achieve?
2. **Quality Measurement and Quality Target Setting:** How will performance be measured and rewarded to align with program goals?
3. **Payment and Cost Target Setting:** How will providers get paid?
4. **Performance Improvement:** What information do you need to be successful?
5. **Program Sustainability:** What types of support will be needed to sustain this program?

3. Current State APM 1 and APM 2

Current State: APM 1 Overview

Background

APM 1 is a primary care value-based payment model developed and implemented as part of HCPF's efforts to shift from paying for volume to paying for improved quality of care through primary care.

How

Providers who are enrolled in APM 1 are paid based on their performance on quality measures using a modified point system for traditional Fee-For-Service payments and a redistribution of payments from lower performers to higher performers. Providers select quality measures to be evaluated on annually.

Program Start Date	2016
Type of Enrollment	• Automatic • Non-Federally Qualified Health Center (non-FQHC) Primary Care Medical Providers (PCMPs) with less than 500 non-geographically attributed members can petition to participate in the program
Qualifying Participants	• Non-FQHC PCMPs with more than 500 non-geographically attributed Members • Eligible Pediatric practices • All Federally Qualified Health Centers (FQHCs)
Quality Measures	• 10 quality measures need to be selected by each participant (3 mandatory determined by HCPF & 7 selected by the PCMP) • Types of measures: Structural, Administrative, and Electronic Clinical Quality Measures (eCQM)

Current State: APM 2 Overview

Background

APM 2 is a payment model for primary care and chronic care management for 12 qualifying chronic conditions. It continues the efforts started with APM 1 to invest in primary care and rewards providers who reduce costs in the 12 chronic conditions by sharing the savings 50/50.

How

This model gives more financial stability to providers by using a combination of:

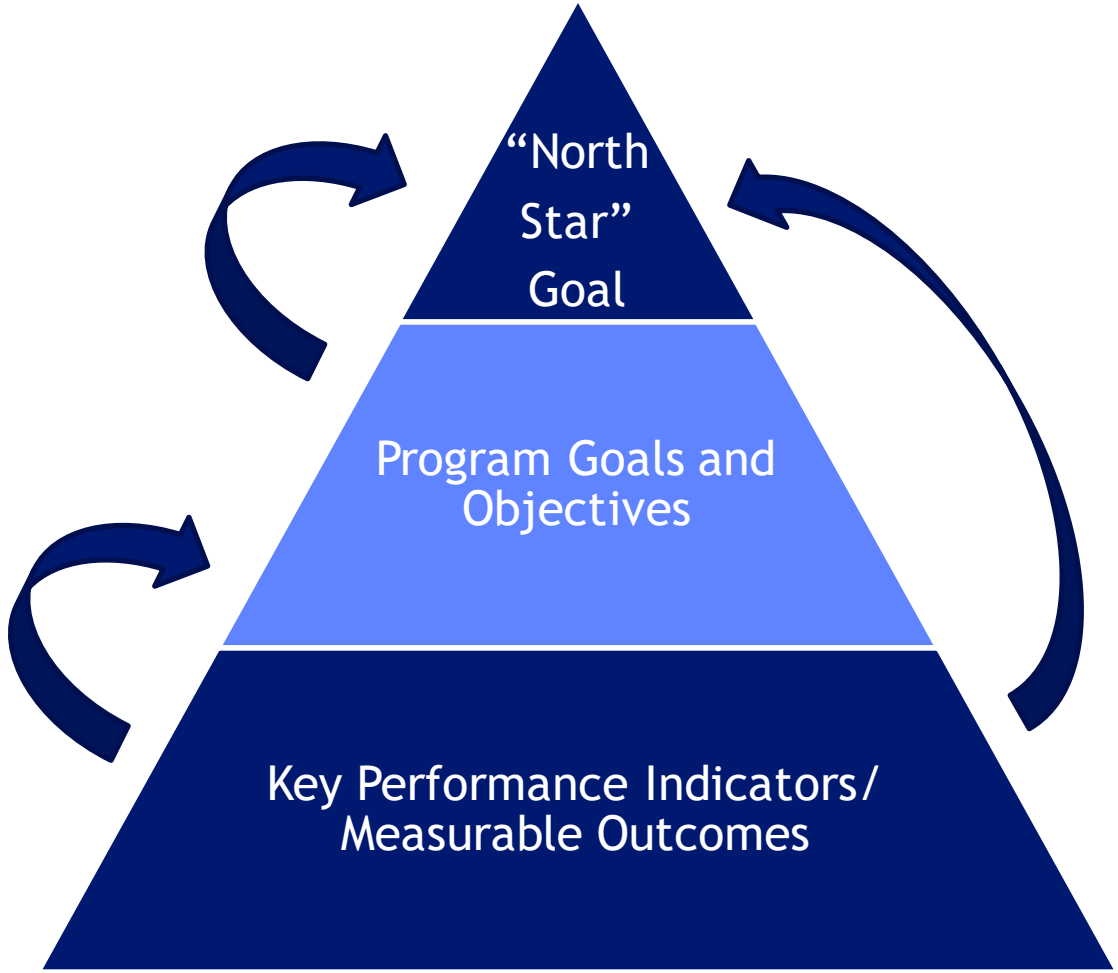
- Monthly advanced Per Member Per Month payment (PMPM)
- Traditional Fee-For-Service (FFS)
- Incentive payments to share in the savings that result from improved chronic care management

PMPM participants are also compensated with any savings realized during reconciliation from shadow billing for PMPM.

Program Start Date	January 1, 2022 (non-FQHCs) & July 1, 2022 (FQHCs)
Type of Enrollment	Voluntary; Eligible participants may enroll on a quarterly basis
Qualifying Participants	• Non-FQHC PCMPs with more than 500 non-geographically attributed Members • Eligible Pediatric practices • FQHCs may sign up for their own track of APM 2
Participant Enrollment Options	• Non-FQHCs can choose to participate in chronic conditions savings only or in both chronic condition savings and PMPM payment. FQHCs may participate in either/both. • Non-FQHC PMPM participants can decide how their payment is split between FFS and PMPM • FQHC participants may only opt into the PMPM at 100%
Quality measures	• 10 quality measures need to be selected by each participant (3 mandatory determined by HCPF & 7 selected by the PCMP) • Types of measures: Structural, Administrative, and Electronic Clinical Quality Measures (eCQM)

4. Goals, Objectives, and Measurable Outcomes for APM 2

What are goals, objectives, and outcomes and how do they connect?



- ✓ The "North Star" defines the top-level overarching goal. ***The North Star sets the direction, which should not change.***
- The supporting goals and objectives for each of the programs that are driving the North Star goal. ***The combination of programmatic goals objectives must align to the North Star goals.***
- The metrics that will be used to measure progress against the programmatic goals and objectives and, subsequently, the North Star goals. ***There must be a clear relationship between improving on the metrics and how that serves the goals and objectives.***

Why do we need goals, objectives, and measurable outcomes?

- To understand what we are trying to achieve by re-designing APM 2
- To focus on key areas of opportunity and ensure alignment to other value-based payment programs and/or broader initiatives across the Medicaid landscape
- To provide a framework to evaluate success of the re-designed program

The ‘North Star’ Goal

“Improving the health, equity, access, affordability, and outcomes for all Coloradans”

Guiding principles – **access**, **affordability**, and **outcomes** – equity & health should be layered into each element of goals, objectives, and outcomes

This ‘North Star’ Goal will be our shared foundation with HCPF as we support HCPF in refining or creating programs to achieve these outcomes.

APM 2 Operational Goals, Objectives, and Outcomes

Operational goals will not be a part of the group discussion, but are meant to indicate additional Department priorities for the APM 2 re-design

Order of Steps

Goals

Reduce administrative burden of program participation

Improve alignment with other payment initiatives

Objectives

- Automate data collection avenues
- Improve the uptake/use of available technologies and tools

- Simplify enrollment & participation selection procedures (measure selection, auto enrollment, etc.)
- Incorporate design considerations from ACC Phase III, PACK, etc., as appropriate

Outcomes

Examples

Reduce occurrence of _ by _ [%, volume] by [year]

Reduce _ by _% for _ patients by [year]

Improve [clinical outcome] from _ to _ by [year]

TBD Based on further design

APM 2 Goals, Objectives, and Outcomes

Order of Steps

Goals	Objectives	Outcomes
Reduce avoidable hospital use for Members & increase use of primary care services	• Reduce avoidable ED utilization and hospital admissions for Members with chronic conditions • Increase utilization of preventative care appointments (i.e., annual check-ups, etc.)	*Examples* **Reduce occurrence of _ by _ [%, volume] by [year]** **Reduce _ by _% for _ patients by [year]** **Improve [clinical outcome] from _ to _ by [year]**
Improve clinical outcomes for Members with chronic conditions	• *Specify objectives for relevant chronic condition(s) once quality measures / data analyses complete*	
Close the gap in racial disparities for primary care outcomes across the state	• Increase sharing of stratified data to understand current disparities & target areas for improvement • Improve the use of culturally competent care approaches	
Close the gap in rural vs. urban disparities for primary care outcomes across the state	• *Specify objectives for specific primary care outcomes once quality measures / data analyses complete*	
Reduce total costs of care while keeping primary care costs per Member stable or higher	• Provide resources to support practice transformation to facilitate appropriate, timely utilization of support resources & programs • Reward primary care practices that demonstrate high-quality care • Keep total cost of care spend equal or lower than current levels	
Provide stabilized revenue and upfront investment into primary care practices	• Assess revenue streams (PMPM, FFS, incentive payments), for consistency & best practice approaches	

TBD Based on further design

Goal/Objective 1 Overview

Improve Access

Reduce avoidable hospital use for Members & increase use of primary care services

Objective	Reduce avoidable ED utilization and hospital admissions for Members with chronic conditions
Objective	Increase utilization of preventative care appointments (i.e., annual check-ups, etc.)

Context: Improve outcomes for members by providing communications or education about appropriate settings of care and emphasize the importance of primary/preventative care

Goal/Objective 2 Overview

Improve Outcomes

Improve clinical outcomes for Members with chronic conditions

Objective	*Specify objectives for relevant chronic condition(s) once quality measures / data analyses complete*

Context: Focus on improving outcomes and reducing costs for the target chronic conditions (utilize more specific objectives further into the design process)

Goal/Objective 3 Overview

Improve Access

Close the gap in racial disparities for primary care outcomes across the state

Objective	Increase sharing of stratified data to understand current disparities & target areas for improvement
Objective	Improve the use of culturally competent care approaches

Context: Consider how to improve the approach to disparities using available data and increase in sharing across Providers, RAEs, etc. to support Providers and Members

Goal/Objective 4 Overview

Improve Access

Close the gap in rural vs. urban disparities for primary care outcomes across the state

Objective	*Specify objectives for specific primary care outcomes once quality measures / data analyses complete*

Context: Acknowledging that rural PCMPs have not been able to participate in VBP work to the same degree, which may be influencing outcomes and support for these practices

Goal/Objective 5 Overview

Improve Affordability

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 & programs
Objective	Reward primary care practices that demonstrate high-quality care
Objective	Keep total cost of care spend equal or lower than current levels

Context: Create additional supports and incentives for practices to make care more affordable and for Providers to continuously improve quality of care

Goal/Objective 6 Overview

Improve Affordability

Provide stabilized revenue and upfront investment into primary care practices

Objective	Assess revenue streams (PMPM, FFS, incentive payments), for consistency & best practice approaches

Context: Original goal of first APM 2 design process in 2020-2021 that requires additional review in the redesign.

5. Looking Ahead

Looking Ahead

Next DRT Session: Wednesday, March 13th from 11:00am – 1:00pm

Topic: Quality Measurement & Quality Target Setting

Resources available for your review:

- APM 2 Program Resources
- APM 101 Videos
  - APM 1
  - APM 2

Questions? Please email us at HCPF_VBPStakeholderEngagement@state.co.us

6. Appendix

Upcoming APM 2 DRT Session Topics

Date	DRT Session	APM Framework Component	APM 2 DRT Session Topic (Subcomponent)
Feb 6	1	DRT Overview	Sessions, Expectations, Background
Feb 28 – today!	2	Goals and Objectives	Feedback on Goals
Mar 13	3	Quality Measurement & Quality Target Setting	Feedback on Quality Measures and targets as well as operationalization
Mar 27	4	Quality Measurement & Quality Target Setting	For Payment (tied to Goals)
Apr 10	5	Payment and Cost Target Setting	Overall process of payment and target setting
Apr 24	6	Payment and Cost Target Setting	Feedback and proposed considerations for attribution method
May 8	7	Payment and Cost Target Setting	Feedback, pros, cons for risk adjustment methodology considerations
May 22	8	Payment and Cost Target Setting	Overall process of reconciliation
June 12	9	Performance Improvement	Actionable insights, provide ‘must haves’, nice to haves
June 26	10	Program Sustainability	Prioritize types of Support