APM 2 Program Design Review Team

Meeting 10
July 10, 2024

Agenda

1. Welcome and Introductions

2. Meeting 9 Recap

3. Discussion: Primary care activities not currently reimbursed under Fee-For-Service (FFS)

4. Looking Ahead

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1. Welcome and Introductions

Meet the APM 2 Team

Araceli Santistevan
APM 2 Lead

Dawson Larance
APM 2 Co-Lead

Taylor Kelley
Design Review Team
Lead Facilitator

Suman Mathur
Design Review Team
Supporting Facilitator

Gerardo Silva-Padron
Design Review Team
Supporting Facilitator

Andy Wilson
APM 2 Support Team

Chelsea Finfer
APM 2 Support Team

Drew Lane
APM 2 Support Team

Janet Milliman
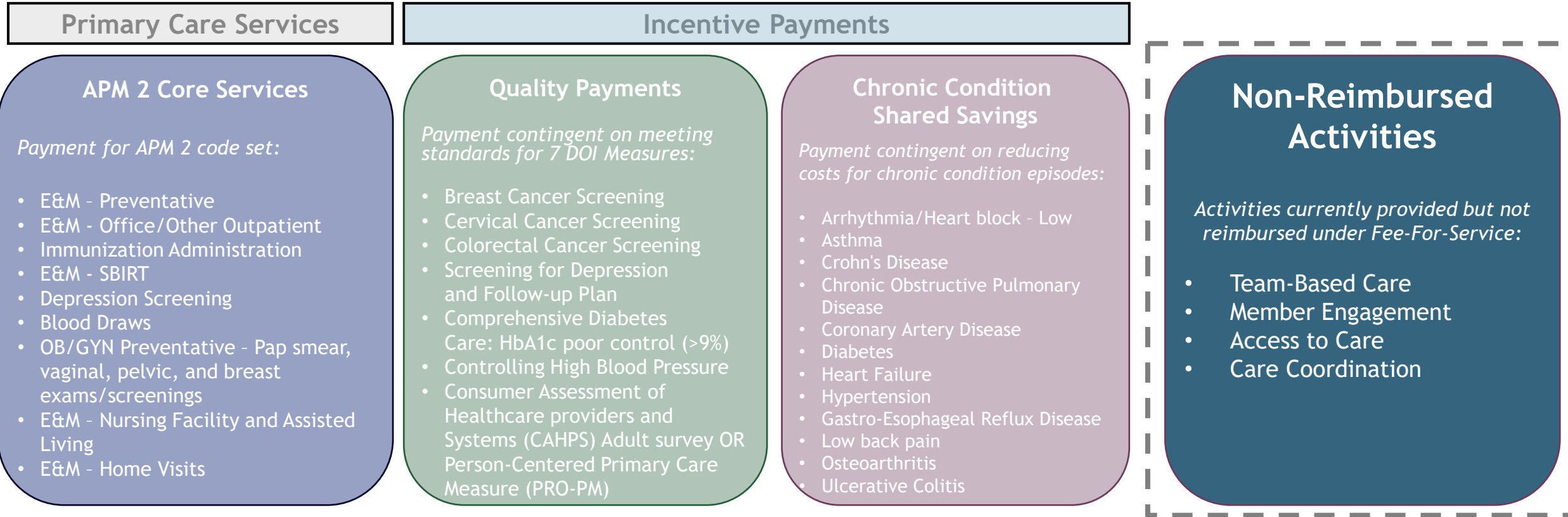APM 2 Support Team

2. Meeting 9 Recap

What We Heard

- Rural practices could use funding for non-traditional delivery of care (in-home, work-site, etc.)

- Small practices could be defined using a provider-to-patient ratio rather than strictly number of providers or panel size

- Suggestion to consider allowing fewer metric requirements to reduce reporting burden for combining adults and pediatric metrics for family practices

- Current payment structure does not support extra time needed to care for medically and socially complex populations

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Key Topics for the Design Review Team

✓ 1. **Goals and Objectives:** What are we trying to achieve?

✓ 2. **Quality Measurement and Quality Target Setting:** How will performance be measured for payment purposes?

3. **Cost Target Setting and Payment Methodology:** 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?

Level-Setting

Today's discussion is **independent** of our previous discussions around prospective payment for primary care services and incentive payments.

Primary Care Services	Incentive Payments		

APM 2 Core Services

Payment for APM 2 code set:

- E&M – Preventative
- E&M - Office/Other Outpatient
- Immunization Administration
- E&M - SBIRT
- Depression Screening
- Blood Draws
- OB/GYN Preventative – Pap smear, vaginal, pelvic, and breast exams/screenings
- E&M – Nursing Facility and Assisted Living
- E&M – Home Visits

Quality Payments

Payment contingent on meeting standards for 7 DOI Measures:

- Breast Cancer Screening
- Cervical Cancer Screening
- Colorectal Cancer Screening
- Screening for Depression and Follow-up Plan
- Comprehensive Diabetes Care: HbA1c poor control (>9%)
- Controlling High Blood Pressure
- Consumer Assessment of Healthcare providers and Systems (CAHPS) Adult survey OR Person-Centered Primary Care Measure (PRO-PM)

Chronic Condition Shared Savings

Payment contingent on reducing costs for chronic condition episodes:

- Arrhythmia/Heart block – Low
- Asthma
- Crohn's Disease
- Chronic Obstructive Pulmonary Disease
- Coronary Artery Disease
- Diabetes
- Heart Failure
- Hypertension
- Gastro-Esophageal Reflux Disease
- Low back pain
- Osteoarthritis
- Ulcerative Colitis

Non-Reimbursed Activities

Activities currently provided but not reimbursed under Fee-For-Service:

- Team-Based Care
- Member Engagement
- Access to Care
- Care Coordination

- Discussions and stakeholder engagement on some of these topics are ongoing. Today's focus is on discussing **primary care considerations** for these topics.
- Feedback may inform future iterations of APM 2, and other HCPF initiatives.

Today's Objectives

1. Identify and get feedback on activities that outpatient primary care practices provide and do not receive reimbursement for under Fee-For-Service (FFS)

2. Understand how these activities may vary across practices and why

3. Discuss the impacts of these activities and their variability on Member and Provider experience

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3. Discussion: Primary Care Activities Not Reimbursed Under FFS

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Primary care activities that are <u>not</u> currently reimbursed under Fee-For-Service

Team Based Care	Member Engagement	Access	Care Coordination
• **Integrated behavioral health*** • Health coaches, care navigators, and community health workers • Recall system for recommended services	• **Health related social needs screening and assistance connecting members to resources*** • Health prevention education and counseling • Member outreach and follow-up • Gathering patient feedback and experience	• Day-time office hours triage and availability of same-day appointments • After-hours triage • Extended hours appointments • **Physical spaces and services are accessible and responsive to patient needs***	• **Care coordination*** • Referral tracking and monitoring • Extended visit time

* This activity covers a spectrum of services and will be explored further in today's discussion.

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Team Based Care

- Integrated behavioral health*

- Health coaches, care navigators, and community health workers

- Recall system for recommended services

* This activity covers a spectrum of services and will be explored further in today's discussion.

Discussion:

1. For **providers:** Are there additional outpatient primary care activities that practices currently perform, which are not reimbursed under FFS and fall under <u>team based care</u>?

   - ➢ How may these activities look different in a rural setting? FQHC? Pediatric primary care?

2. For **members**: Under <u>team based care</u>, what are the types of things your PCMP does that positively impact your care?

3. How feasible is it for practices to implement these activities? Is there variability in how these activities are offered or what they look like across practices?

4. For **providers:** How well are the RAE payments you're currently receiving for these activities serving your needs?

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HCPF

Deep Dive: Integrated Behavioral Health (BH)

Example derived from DOI Core Competencies

Foundational	Enhanced	Advanced
• Practices develop a vision for behavioral health integration and identifies key services that could be added to improve comprehensiveness of care • Practices offer referral pathways for patients • Ex: screening & assessment	*Foundational activities plus:* • Practices offer medication management for certain behavioral health conditions. • Practices utilize telehealth or a contracted provider for BH integration • Ex: BH training, care coordination	*Enhanced activities plus:* • Practice has implemented BH integration with provider on-site • Referral sources have appointment availability and track referral completion

Discussion:

1. Does this model resonate for integrated behavioral health for primary care practices?

2. How feasible is it for practices to implement these activities and progress across levels? How does feasibility of progression vary among providers in Colorado?

Member Engagement

- Health related social needs screening and assistance connecting members/ families to resources*

- Health prevention education and counseling

- Member outreach and follow-up

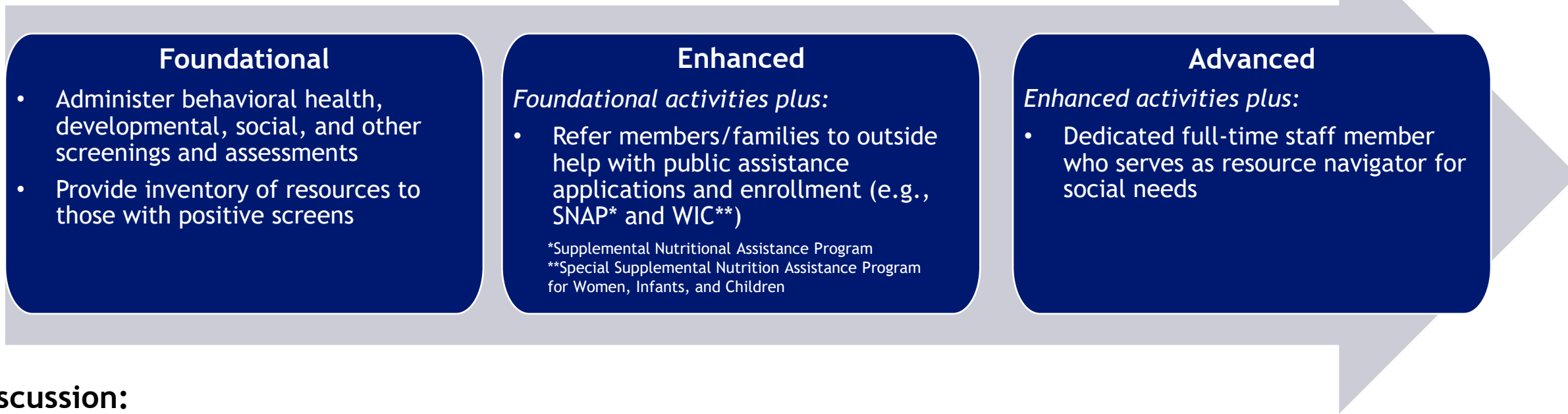- Gathering patient feedback and experience

* This activity covers a spectrum of services and will be explored further in today's discussion.

Discussion:

1. For **providers:** Are there additional outpatient primary care activities that practices currently perform, which are not reimbursed under FFS and fall under <u>member engagement</u>?

   ➤ How may these activities look different in a rural setting? FQHC? Pediatric primary care?

2. For **members:** Under <u>member engagement</u>, what are the types of things your PCMP does that positively impact care?

3. How feasible is it for practices to implement these activities? Is there variability in how these activities are offered or what they look like across practices?

4. For **providers:** How well are the RAE payments you're currently receiving for these activities serving your needs?

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Deep Dive: Health Related Social Needs (HRSN) Screening and Assistance

Example derived from [Massachusetts Primary Care Sub-Capitation Program](#)

Foundational
- Administer behavioral health, developmental, social, and other screenings and assessments
- Provide inventory of resources to those with positive screens

Enhanced
Foundational activities plus:
- Refer members/families to outside help with public assistance applications and enrollment (e.g., SNAP* and WIC**)

*Supplemental Nutritional Assistance Program
**Special Supplemental Nutrition Assistance Program for Women, Infants, and Children

Advanced
Enhanced activities plus:
- Dedicated full-time staff member who serves as resource navigator for social needs

Discussion:

1. Does this model resonate for health-related social needs screening and assistance for primary care practices?

2. How feasible is it for practices to implement these activities and progress across levels? How does feasibility of progression vary among providers in Colorado?

Access

- Day-time office hours triage and availability of same-day appointments

- After-hours triage

- Extended hours appointments

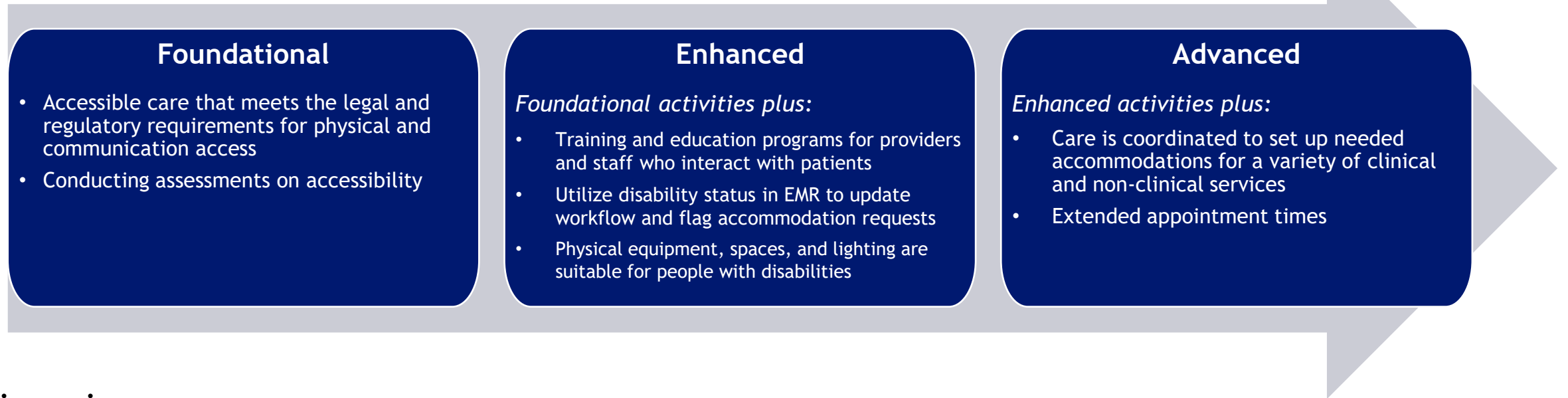- Physical spaces and services are accessible and responsive to patient needs*

* This activity covers a spectrum of services and will be explored further in today's discussion.

Discussion:

1. For **providers:** Are there additional outpatient primary care activities that practices currently perform, which are not reimbursed under FFS and fall under access?

   ➢ How may these activities look different in a rural setting? FQHC? Pediatric primary care?

2. For **members:** Under access, what are the types of things your office does that positively impact care?

3. How feasible is it for practices to implement these activities? Is there variability in how these activities are offered or what they look like across practices?

4. What is the role of telemedicine or portal messaging in outpatient primary care?

5. For **providers:** How well are the RAE payments you're currently receiving for these activities serving your needs?

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Deep Dive: Physical Spaces and Services Accessible and Responsive to Patient Needs

Example derived from HCPF & CHI Disability Competent Care in Primary Care Recommendations Memo

Foundational

- Accessible care that meets the legal and regulatory requirements for physical and communication access
- Conducting assessments on accessibility

Enhanced

Foundational activities plus:

- Training and education programs for providers and staff who interact with patients
- Utilize disability status in EMR to update workflow and flag accommodation requests
- Physical equipment, spaces, and lighting are suitable for people with disabilities

Advanced

Enhanced activities plus:

- Care is coordinated to set up needed accommodations for a variety of clinical and non-clinical services
- Extended appointment times

Discussion:

1. Does this model resonate for accessible physical spaces and services that are responsive to patient needs for primary care practices?

2. How feasible is it for practices to implement these activities and progress across levels? How does feasibility of progression vary among providers in Colorado?

Care Coordination

- Care coordination*

- Referral tracking and monitoring

- Transitions of care

* This activity covers a spectrum of services and will be explored further in today's discussion.

Discussion:

1. For **providers:** Are there additional outpatient primary care activities that practices currently perform, which are not reimbursed under FFS and fall under care coordination?

   ➢ How may these activities look different in a rural setting? FQHC? Pediatric primary care?

2. For **members:** Under care coordination, what are the types of things your office does that positively impact care?

3. How feasible is it for practices to implement these activities? Is there variability in how these activities are offered or what they look like across practices?

4. For **providers:** How well are the RAE payments you're currently receiving for these activities serving your needs?

Deep Dive: Care Coordination

Example derived from [Colorado State Innovation Model](#)

Foundational

- Employs a care coordinator to facilitate communication among care providers and members
- Provides educational tools to manage health conditions at home

Enhanced

Foundational activities plus:

- Performs proactive outreach and facilitates bi-directional communication with other **practices** to support *medical specialty care*
- Establishes a system to track referral and intake for specialty services and for follow-up on appointments
- Supports transition of care (e.g., emergency department, inpatient hospital)

Advanced

Enhanced activities plus:

- Performs proactive outreach and facilitates bi-directional communication with other practices and community organizations to support *whole-person care* (e.g., schools, housing, criminal justice systems)

Discussion:

1. Does this model resonate for care coordination for primary care practices?

2. How feasible is it for practices to implement these activities and progress across levels? How does feasibility of progression vary among providers in Colorado?

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4. Looking Ahead

What's Next

- **Next DRT Session:** Wednesday, July 24th from 11:00am – 1:00pm

- **Resources** available for your review:
  - Team Charter
  - APM 2 Program Resources
  - APM 101 Videos
    - APM 1
    - APM 2

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

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Upcoming DRT Meeting Topics

Date	DRT Session	APM Framework Component	APM 2 DRT Session Topic (Subcomponent)
Feb 6	1	DRT Overview	Sessions, expectations, background
Feb 28	2	Goals and Objectives	Feedback on goals
Mar 13	3	Quality Measurement and Quality Target Setting	Feedback on quality measures and targets as well as operationalization
Mar 27	4	Payment	Feedback and proposed considerations for attribution method
Apr 24	5	Quality Measurement and Quality Target Setting	Feedback on quality target setting methodology
May 8	6	Office Hour	Questions and feedback
May 22	7	Quality Target Setting	Feedback on quality target setting methodology
June 12	8	Payment	Feedback on prospective payment and reconciliation process
June 26	9	Program Sustainability	Considerations for varying provider types & populations
July 10 – Today!	10	Payment	Joint accountability and care coordination
July 24	11	Performance Improvement and Program Sustainability	Actionable insights and needed supports, resources, and data

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Questions?