COLORADO
Department of Health Care Policy & Financing

Payment Alternatives for Colorado Kids (PACK)
Design Review Team (DRT)
Meeting Minutes

April 24, 2024
5:00 P.M. to 7:00 P.M.

1. Introductions

Suman Mathur called the meeting to order.

The following DRT participants were in attendance: Alison Keelser, Amber Griffin, Andrea Loasby, Cassie Littler, David Keller, Ealasha Vaughner, Hillary Jorgensen, Hoke Stapp, Jane Reed, Laura Luzietti, Mark Gritz, Melissa Buchholz, Mike DiTondo, Robert Haywood, Sarrah Knause, and Toni Sarge. Other attendees included Devin Kepler (HCPF), Katie Price (HCPF), Helen Desta-Fraser (HCPF), Nicole Nyberg (HCPF), Peter Walsh (HCPF), Breelyn Brigola (Stakeholder Engagement (SE) Team), Emily Leung (SE Team), Suman Mathur (SE Team), Andy Wilson (PACK Support Team), Puja Patel (PACK Support Team), and Samantha Block (PACK Support Team).

2. Meeting 4 Recap

Suman Mathur recapped major discussion points from the previous meeting about ACC Phase III attribution methodology.

Emily Leung presented DRT Session #4 meeting minutes for approval, which DRT participants approved.

3. Quality Target Setting and Reward Structure

Emily Leung highlighted that quality target setting was the priority of this meeting. She emphasized that the quality target setting should be considered in relation to the Division of Insurance (DOI) measures linked to payment.

Samantha Block described the differences between Quality Goals, goals where the Department aims for future performance, and reward structure, the way in which financial incentives are structured to support achievement of the Department's Quality Goals. She emphasized that the focus of today's conversation was to discuss options for each of the reward structure components to inform PACK model design. Samantha also explained the importance of target setting and how setting targets for each measure tied to payment can help measure the success of PACK goals and associated objectives.

Samantha presented the five (5) guiding principles for a reward structure:

1. **Supports High Performance:** The reward approach should reward those that are already high performers to stay at that level or, if possible, to improve and encourage those that are not high performers to continuously improve.
2. **Makes Rewards Achievable:** The reward structure supports a system where participants feel that achieving rewards is within reach based on where performance currently stands.
3. **Scales the Size of the Reward to Effort:** Rewards should be reflective of the level of effort required to improve.
4. **Supports Predictability:** The level of anticipated reward needs to be predictable for a period of time.
5. **Draws from Evidence-Based Observations:** The ability to improve and get closer to targets is supported by national, state, and regional benchmarks when available.

The SE Team invited DRT participants to reflect on these guiding principles, specifically asking which guiding principles they resonated with the most, if any principles were missing, and if any should be changed.

DRT participant questions are summarized below:

- A DRT participant noted that rewarded progress and improvement towards the goal should be included in addition to incentivizing high performance.
- A DRT participant stated that performance should be rewarded for maintenance and acknowledged a close the gap methodology (see below for an explanation) ensures program participants are trying to improve rather than simply reach a standard.
- A DRT participant stated there should be consideration in the infrastructure for uncontrollable circumstances which negatively impact providers. Participants recalled the impact of the pandemic on emergency department usage, which resulted in skewed data when the usage returned to normal levels.

Nicole Nyberg presented the Department's current target setting methodology, which is a close the gap methodology, based on a statewide goal set by the Department for each measure. She explained that with this methodology, primary care medical practices (PCMPs) are measured against their own historical baseline, rather than against other practices, so reward is based on improvement, not absolute performance. She shared an example of a close the gap calculation, where the Department goal is set at 70%, the practice meets 40% performance in the baseline year, and the gap from baseline performance to the Department goal is 30%. She explained that with close the gap, if the practice improves 3 percentage points to 43% in the following year, the practice has closed the performance gap by 10% and

therefore be awarded full points for this measure. Nicole also referenced the DOI Regulation 4-2-96 Pediatric Measure Set to level set the conversation on reward structure.

4. Presentation and Discussion on Key Components of Any Reward Structure

Note that discussion questions posed to DRT participants were based on proposed components of a reward structure. However, some feedback and responses may refer to the current close the gap payment methodology (explained above) currently adopted by HCPF (known as 'Department').

Andy Wilson stated that there may be variation for provider performance for different quality measures and presented three potential measure scenarios, which are bottom clustering, even distribution, and top clustering.

Andy then defined and presented some key components of any reward structure, which include the following.

- **HCPF Goal (Department Stretch Goal):** Where the Department aims for performance in the future.
- **Commendable Area:** Represents high performers, who will get 100% of the reward.
- **Commendable Threshold:** Maximum threshold based on reasonable attainment where all performance above is rewarded.

Suman Mathur facilitated a conversation surrounding Commendable Thresholds and asked DRT participants if there should be a performance level that is so good that providers should receive 100% reward. Suman also asked whether this threshold should be the same as HCPF's "Department Stretch Goal," or HCPF's goal for a measure.

DRT participant comments/questions and staff responses regarding commendable thresholds are summarized below:

- A DRT participant sought clarification on the risk pool and available rewards in the PACK program, with the Department indicating decisions are yet to be made and inviting suggestions.
- DRT participants discussed the relevance of shared savings in pediatric care, with a consensus emerging that it may not be suitable due to the difficulty in achieving significant cost savings in pediatrics.
    - Some DRT participants wondered whether PACK would implement an upside risk only payment model. DRT participants noted that if not upside only, this could impact providers' willingness to take on Medicaid patients and/or participate in PACK.

- DRT participants described challenges of the close the gap methodology for top performers and advocated for setting an attainable commendable threshold to address potential barriers.
- A DRT participant suggested an extra bonus or reward for surpassing a commendable threshold to incentivize top performance.
- A DRT participant argued that rewards should genuinely reflect performance improvements, cautioning against penalizing low performers to not deplete rewards for high achievers.
- Some DRT participants expressed confusion around the difference between the Department's Stretch Goals and a commendable threshold.
    - A DRT participant wondered whether the commendable threshold is more provider-focused or more so for Department purposes.
    - DRT participants thought it may be more useful to keep the Department Stretch Goals internal to the Department and instead share the commendable threshold with providers.
    - DRT participants suggested to lower the Stretch Goal if the concern is that there are commendable thresholds that are set too high.
- DRT participants discussed the possibility of adjusting the commendable threshold over time to encourage continuous improvement and participation, highlighting the challenge of further improvement once high performance is reached.
    - A DRT participant believed that the commendable threshold should remain the same across the three cluster scenarios of actual performance (bottom, even, and top). While the participant believed that ample evidence would be necessary to move the commendable threshold, other DRT participants thought establishing a mechanism for providers to monitor and modify commendable threshold setting with the Department was a good idea.
    - A DRT participant suggested if goals are to be adjusted over time, there should be a period of stability to encourage participation in the PACK program.
- DRT participants debated the concept of transitioning from the commendable threshold to Department Stretch Goals, with some DRT participants questioning the rationale behind retiring a measure once a commendable threshold is achieved. Some DRT participants described the DOI Regulation 4-2-96 Pediatric Measure Set as the "bread and butter" of pediatrics, therefore advocating that retirement of these measures would not be appropriate given that it is still important to maintain high performance levels.
- DRT participants voiced concerns about the administrative burden of implementing process measures for pay-for-performance, emphasizing the complexity and time-consuming nature of value-based care.

- DRT participants discussed the importance of ensuring increased earnings for pediatric providers are stable and not subject to withdrawal, to maintain Medicaid participation and focus on fundamental pediatric care measures.
- DRT participants agreed that the main priority for PACK should be to incentivize practices to participate in the value based payment model in order to "keep the lights on."
- A DRT participant asked if there were current incentives for DOI Regulation 4-2-96 Pediatric Measure Set, besides the Regional Accountable Entities (RAE) contracts, and if PACK would replace measures already in place for other programs like APM 1.
    - Staff responded that if a practice participates in PACK program, then the practice will not participate in APM 1.
    - The DRT participant suggested that the PACK program must have at least a 4% gain for pediatricians to participate to make up for the difference that providers are receiving in APM 1.

After Suman Mathur clarified that the framing for this discuss is to think about a potential model that is only upside risk for providers, Samantha Block described that the flip side of the Commendable Threshold is the Minimum Acceptable Area, which is bounded by the Minimum Acceptable Threshold.

- **Minimum Acceptable Threshold:** Minimum threshold based on minimum acceptable standards where all performance below is not rewarded.

The SE team asked DRT participants if there should be a performance level that is too poor below which no reward should be given.

DRT participant comments/questions and staff responses pertaining to minimum acceptable thresholds are summarized below:

- A DRT participant questioned the necessity of a minimum threshold within a close the gap methodology, emphasizing that the close the gap methodology would reward practices if they showed improvement, which focuses on improving the lowest performers.
    - The support team suggested considering alternatives beyond the current close the gap methodology.
- DRT participants discussed the relevance of adjusting the minimum acceptable threshold, especially for process metrics outside a close the gap methodology.
- A DRT participant supported the idea of incentivizing effort and improvement to prevent discouragement among providers. It was suggested that outside a close the gap methodology, different thresholds with varying rewards would be necessary to avoid an all-or-nothing reward scenario.
- DRT participants agreed on the importance of setting varying thresholds across scenarios (bottom clustering, even distribution, top

clustering) to enhance provider support without undermining quality improvement goals.
- A DRT participant highlighted the relevance of a minimum threshold in high-performing scenarios to ensure continuous incentives even after goals are met, proposing a threshold at two standard deviations below the expected minimum to account for random variation, and emphasized the importance of regularly monitoring measures.
    - The support team concurred that a minimum threshold could be necessary, particularly in non-close the gap scenarios, acknowledging the need for flexibility and variation across performance scenarios.

Lastly, Andy Wilson highlighted the area between the Commendable Threshold and the Minimum Acceptable Threshold, and invited DRT participants to think through options for what this could look like in a PACK model.

The SE team facilitated a discussion about rewarding between commendable and minimum acceptable thresholds (Question: For each example measure, should each improvement step count the same? Example: for a high performer improving x percentage versus a lower performer improving x percentage).

DRT participant comments/questions and staff responses pertaining to the area between the commendable and minimum acceptable thresholds are summarized below:

- DRT participants expressed concerns about the operational complexity of the proposed target setting methodology, stressing the importance of simplicity for providers to understand potential payments easily.
- A DRT participant specifically explained that target setting methodology should not vary between measures to reduce complexities.
- A DRT participant emphasized importance of a mechanism to close the performance gap through incentives that will promote increased performance.
- A DRT participant sought clarification on pay-for-performance payments, inquiring if reaching the commendable threshold suffices for full payment, highlighting the potential benefits of a close the gap methodology in rewarding improvement.
    - The Department confirmed that providers meeting or exceeding the commendable threshold would receive full pay-for-performance payments.
- DRT participants acknowledged the target setting methodology involving commendable and minimum acceptable thresholds as complex, but suggested it was logical, proposing adjustments based on performance progression or regression.

- A DRT participant requested more clarity on the purpose of Department Stretch Goals, especially in scenarios where performance is already high, and improvement opportunities are limited.
    - The Support Team explained the balance between rewarding achievement and recognizing improvement, emphasizing that the approach depends on current performance levels.
- A DRT participant proposed considering direct incentives for providers (ex: checks to providers) and questioned the feasibility of state-led provider payment instead of only practice-based compensation.
- A DRT participant clarified their understanding of the pay-for-performance model, focusing on rewarding progress towards and maintenance of performance at the commendable threshold.
- A DRT participant inquired about the future use of Key Performance Indicator (KPI) pools for achieving Department Stretch Goals.
- A DRT participant emphasized the crucial role of support staff in executing program goals.
- A DRT participant inquired about the Department and RAEs providing support through coaching for model design transitions, with the Support Team acknowledging the need and mentioning ongoing initiatives and future discussions.

5. Looking Ahead

Suman Mathur provided a list of resources and reminded DRT participants about the next meeting about payment on May 8th from 5-7pm. She also noted that the PACK DRT will be using the July 10, 2024, calendar hold for a DRT meeting. Suman then closed the meeting.