COLORADO
Department of Health Care Policy & Financing

Payment Alternatives for Colorado Kids (PACK)
Design Review Team (DRT)
Meeting Minutes
July 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: Amber Griffin, Cassie Littler, David Keller, Ealasha Vaughner, Erica Pike, Hillary Jorgensen, Jane Reed, Laura Luzietti, M. Cecile Fraley, Melissa Buchholz, Robert Haywood, and Sarrah Knause.

Other attendees included Devin Kepler (Department of Health Care Policy and Financing [HCPF]), Katie Price (HCPF), Breelyn Brigola (Stakeholder Engagement (SE) Team), Emily Leung (SE Team), Suman Mathur (SE Team), Christine Kim (PACK Support Team), Puja Patel (PACK Support Team), and Samantha Block (PACK Support Team).

2. Level-Setting

Emily Leung presented DRT Meeting #10 minutes for approval and reminded DRT participants of the PACK North Star Goal. There were no objections to the meeting minutes.

Prefacing that today was the last DRT meeting guiding the PACK program design process, Emily shared the objectives of today's DRT meeting:

1. Share a high level roadmap of PACK model design.
2. Review stakeholder feedback received throughout the DRT and gather remaining insight.
3. Understand next steps in PACK program design, and how stakeholder feedback will be reviewed and incorporated.

3. PACK Design Roadmap

Suman Mathur shared a visual of the PACK roadmap to contextualize the work of the DRT, and how it fits into where we've been, where we are currently, and how stakeholder feedback may inform program design, and eventually, PACK implementation. Steps highlighted on the PACK roadmap include:

1. Understand current state
2. Design Review Team (DRT) kick-off
3. Ongoing discussions with DRT
4. Program design informed by DRT feedback
5. PACK Soft Launch
6. PACK implementation

Suman explained that within this roadmap, we are currently wrapping up discussions with the DRT, and that program design will be informed by DRT feedback through subsequent discussions with the PACK Support Team and the Department.

Suman also assured DRT participants that feedback gathered from these DRT meetings have and will continue to be used to inform PACK program design. She reviewed the decision-making process:

1. HCPF and support team present design elements to the DRT
2. DRT provides feedback on design elements
3. HCPF reviews and incorporates feedback into design

4. DRT Feedback Recap

Suman Mathur reminded DRT participants of the five key topics, provided below, that guided the DRT process over the course of 10 meetings, and reiterated that today's discussion is intended to wrap up what we've heard throughout these sessions, provide opportunities to offer additional feedback and ask questions, and understand what's next for PACK.* She also noted that relevant past DRT materials are provided in the Appendices for reference.

- **Goals and Objectives:** What are we trying to achieve?
- **Quality Measurement and Quality Target Setting:** How will performance be measured for both informational and payment purposes?
- **Payment:** What adjustments to payment are needed to adequately support high-value care delivery? What is the mechanism of how providers will be paid?
- **Performance Improvement:** What information do you need to be successful?
- **Program Sustainability:** What types of support will be needed to sustain this program?

*The SE Team presented high-level takeaways and facilitated associated discussions for each of the key topic areas.

<u>Overarching Feedback</u>

Emily Leung shared the following points as overarching feedback heard throughout the DRT convening process:

- Pediatric primary care is distinct from adult primary care, and it should be recognized as such in a value based payment model.
    - Focus is on providing preventive services more than treating chronic conditions.
    - Care for a pediatric patient is dynamic and requires frequent and timely visits.
    - The provision of pediatric services should be responsive to family needs.
- Low reimbursement exacerbates pediatric practices' financial solvency.
- Pediatric practices with a high Medicaid payer mix, as well as rural and small pediatric practices, experience financial barriers.

- Attribution accuracy and data integrity pose challenges, especially for pediatric practices.
- Goals and objectives, quality measures, and programmatic components should be aligned with other alternative payment models (APMs) and Accountable Care Collaborative (ACC) Phase III.

The SE Team facilitated a discussion surrounding overarching DRT feedback with the following discussion questions posed to DRT participants:

- Are the themes correctly capturing the discussion on overarching feedback?
- Is there additional feedback or comments on overarching feedback that should be considered when designing PACK?

Questions and feedback from DRT participants are below:

- A DRT participant suggested to include sports physicals in PACK measures.
- A DRT participant elevated the need for behavioral health supports for youth, as there are practices struggling to fund behavioral health services.
- DRT participants suggested increasing incentives for after-hours care to accommodate patients unable to take time off from work or school, and addressing the financial constraints of holding open appointments without reimbursement.
- A DRT participant highlighted that there are age distinctions within the pediatric category, with infants and the youngest children having different needs from adolescents and young adults.

Goals and Objectives

Suman Mathur presented DRT feedback on goals and objectives. These include:

- Proposed goals and objectives are aligned with what DRT members believe is important to providers and Health First Colorado members.
    - Some goals and objectives may be outside the scope of PACK or beyond control of the provider (e.g. Goals 3 and 4).
    - Financial barriers associated with low Medicaid reimbursement pose challenges to achieve goals and objectives.

She also noted that relevant past DRT materials on goals and objectives were located in Appendix A.

The SE Team facilitated a discussion surrounding goals and objectives feedback with the following discussion questions posed to DRT participants:

- Are the themes correctly capturing the discussion on goals and objectives?
- Is there additional feedback or comments on goals that should be considered when designing PACK?

Questions and feedback from DRT participants are below:

- DRT participants reiterated that financial barriers can pose challenges to achieving program goals and objectives, and that payments need to be commensurate to assure providers can work towards achieving these goals and objectives. DRT participants recognized the Department's limitations of perhaps not having "a bigger pie" to pull financial resources from.
    - A DRT participant commented on how a limited number of quality measures and options for pediatrics, which could be imbued in data challenges, can also pose barriers for pediatric practices. In addition to immunizations, pediatric practices often deal with factors beyond provider control.
- DRT participants suggested that PACK needs to offer substantial incentives to ensure meaningful participation and address concerns of program sustainability within the financial limitations of HCPF, indicating a balance between administrative burden and financial considerations is crucial for the program's success.

Quality Measures and Quality Target Setting

Emily Leung acknowledged that quality measures and quality target setting were discussed at length over the course of several DRT meetings, and stated that feedback and discussion time were organized into two separate sections. She noted that relevant past DRT materials quality measures and quality target setting were located in Appendix B.

Quality Measurement
Emily first presented stakeholder takeaways on quality measures. She referenced the six Division of Insurance (DOI) pediatric measures and shared the following points:

- Additional informational measures, that focus on clinical outcomes, were suggested.
- Possible challenges for the proposed measures include:
    - Meeting immunization measures due to vaccine hesitancy
    - Disaggregating data on certain measures by race/ethnicity given small sample size
- Measuring patient experience is important, but current assessment tools (e.g. Consumer Assessment of Healthcare Providers & Systems (CAHPS)) have limitations.
    - Suggestions to use continuity of care and patient retention rates to assess patient experience

The SE Team facilitated a discussion surrounding quality measurement with the following discussion questions posed to DRT participants:

- Are the themes correctly capturing the discussion on quality measurement?
- Is there additional feedback or comments on quality measurement that should be considered when designing PACK?

Questions and feedback from DRT participants are below:

- A DRT participant shared that practices that serve both patients with commercial and Health First Colorado plans have additional challenges regarding coding and billing since these processes differ. For example, developmental screening and postpartum depression screening can be inaccurately coded as commercial rather than Medicaid. These different processes add complexity in billing and measuring quality measures.
- A DRT participant reiterated that some practices have multiple sites and wondered how this would be considered when calculating quality performance.
- DRT participants discussed measuring patient experience through continuity of care and patient retention rates, proposing patient engagement as an indicator, such as the use of integrated behavioral health and care coordination services.
- DRT participants mentioned using simple quarterly parent satisfaction surveys to assess patient satisfaction, suggesting the potential for EHR systems and different platforms to disseminate these surveys.
- DRT participants agreed on the usability of simpler surveys over lengthy validated tools like the CAHPS survey for timely practice improvements, mentioning the G2211 "continuity of care" code as a useful measure of care coordination.
- DRT participants called for timely reporting of quality measures from HCPF, emphasizing the need for prompt data to make effective changes, especially considering the rapid aging out of pediatric cohorts.

Quality Target Setting
Emily then presented takeaways on quality target setting, reminding DRT participants of terminology:

- Commendable Threshold: Maximum threshold based on reasonable attainability where all performance above is rewarded. This is equivalent to the HCPF Goal (e.g., Stretch Goal).
- Commendable Area: High performers, who are above the Commendable Threshold and would be eligible for 100% of the reward.
- Minimum Acceptable Threshold: Based on minimum acceptable standards where all performance below is not rewarded.
- Minimum Acceptable Area: Low performers, who are below the Minimum Acceptable Threshold and would be eligible for 0% reward.

She provided the following points:

- An achievable commendable threshold makes sense for PACK.
- A minimum acceptable threshold could make it harder for already struggling pediatric providers to receive any additional financial support.
- A tiering structure to assess performance between thresholds allows for more of a buffer for performance and better accounts for both statistical variance and external factors.
    - Some DRT members preferred the current “close the gap” methodology (e.g. relative improvement) over absolute threshold (achievable and minimum acceptable threshold) as it incentivizes continual improvement and is more achievable for low performers.

The SE Team facilitated a discussion surrounding quality target setting with the following discussion questions posed to DRT participants:

- Are the themes correctly capturing the discussion on quality target setting?
- Is there additional feedback or comments on quality target setting that should be considered when designing PACK?

Questions and feedback from DRT participants are below:

- A DRT participant shared that both elements (a commendable threshold and close-the-gap methodology) are needed.
    - DRT participants shared their preference for the current close-the-gap methodology for lower performers, while higher performers would have an easier time meeting a commendable threshold, which should be attainable and specific to Colorado.
    - A DRT participant raised concern that a minimally acceptable threshold alone might not motivate practices to exert extra effort.
- DRT participants emphasized how providers need to feel confident that they will benefit from the program in order to participate; a potential strategy would be to lower the minimum threshold. They cautioned against disincentivizing "lower performers" from participating in PACK due to the risk of receiving no incentive dollars due to low performance.

<u>Payment</u>

Suman Mathur presented feedback on payment topic discussions, ranging from shared savings and total cost of care (TCOC) models to provider types. Relevant past DRT materials are referenced in Appendices C and D. She shared feedback organized by payment topic:

Payment Overview

- Shared savings and total cost of care (TCOC) models are not appropriate for pediatric primary care. There are few chronic conditions and minimal over-utilization, return on investment for pediatric primary care services likely takes decades, and some cost savings occur outside of the healthcare systems.
- Due to pediatric focus on prevention, high quality pediatric care may lead to increased utilization of preventative services.
- Prospective payment with reconciliation pose challenges of administrative burden and unpredictability.
- Pay-for-performance is appropriate for PACK as long as this results in additional dollars on top of base fee-for-service and avoids downside risk.

Payment: Non-Billable Services

- There are a host of non-billable services that drive value in pediatrics (e.g. nurse phone triage).
- Provision of non-billable services and ability to progress in practice capabilities are limited by constrained financial resources.
- Current RAE payments, which vary across regions, do not fully cover expenses of current and enhanced non-billable services.

- Provision of non-billable services like care coordination may look differently across practice types (e.g. rural or small providers) due to patient needs, staffing, and available external regional resources.

Payment: Provider Types

- Pediatric practices have a high Medicaid proportion in their payer mix, resulting in lower aggregate reimbursement to the practice.
- Small practices, which should be defined based on the number of provider FTE, may struggle with alternative payment model adoption due to limited capacity and technology.
- Limited access to pediatric specialists in rural areas means that pediatric PCMPs must manage more complex care within their practice compared to adult primary care.
- School based health centers may serve as an increased access point despite not serving as a member's medical home.

The SE Team concurrently facilitated a discussion surrounding payment with the following discussion questions posed to DRT participants:

- Are the themes correctly capturing the discussions on payment?
- Is there additional feedback or comments on payment that should be considered when designing PACK?

Questions and feedback from DRT participants are below:

- Referencing the *Payment Overview* section, a DRT participant highlighted that there is certainly high utilization of preventative services in pediatrics, resulting in higher short-term costs.
- Referencing the *Non-Billable Services* section, DRT participants shared that the ability to provide non-billable services is not only limited by practice-level financial constraints, but also workforce and licensure issues more specifically.
    - There are shortages of pediatric-specific trained workforce (e.g., Integrated Behavioral Health (IBH), nursing, etc. across different domains).
    - The combination of higher reimbursement for behavioral medical services by Medicaid and commercial payers along with a trend toward telehealth have drawn trained professionals out of the pediatric IBH field.
    - Pediatric practices are currently depending on grant funding to sustain non-billable services.
    - DRT participants discussed creative strategies to address workforce shortages, such as utilizing nurses and care coordinators for base-level mental health services after training, which helps in managing patient needs more efficiently. However, they noted the lack of billing mechanisms for these professionals, impacting financial sustainability.
- Referencing the *Provider Types* section, DRT participants clarified that "some", not all, practices have a high Medicaid proportion as part of their payer mix. This has implications on whether pediatric practices with a lower Medicaid proportion in their payer mix engage in Medicaid APMs.

Performance Improvement

Emily Leung shared DRT feedback on dashboard design as it relates to performance improvement. She stated that thought different dashboard view capability are needed for RAEs and providers, performance insights should be shared at both levels to increase transparency. She also presented takeaways organized by dashboard design areas:

Attribution

- Monthly reporting cadence
- Information about where attributed patients are receiving care may be helpful
- Attribution methodology and transparency for fixing errors

Quality Measurement and Targets

- Additional context on metrics and performance (e.g. thresholds, confidence intervals, relevant technical specifications)
- Longitudinal trends
- Data drill down
- Data dashboard customization

Informational Items

- Utilization patterns for different service types (e.g. mental health, therapies, ED, urgent care, inpatient care, physical therapy (PT), and occupational therapy (OT))
- Pharmacy claims can help assess medication management and total cost of care

The SE Team facilitated a discussion surrounding dashboard design feedback with the following discussion questions posed to DRT participants:

- Are the themes correctly capturing the discussion on dashboard design for performance improvement?
- Is there additional feedback or comments on dashboard design that should be considered when designing PACK?

Questions and feedback from DRT participants are below:

- A DRT participant reiterated the utility of providers receiving claims data feeds in addition to data available through the dashboard. This would allow practices the ability to integrate data feeds they receive from commercial insurers in order to look at the practice as a whole.

Program Sustainability

Lastly, Suman Mathur presented DRT feedback related to technical assistance as part of program sustainability:

- Practice transformation should be pediatric specific.

- Practice transformation efforts that are initiative-focused may increase administrative burden for providers who participate in multiple programs, particularly if not all programs are pediatric-focused.
- To establish and maintain trust between entities, it is important that providers have a venue to discuss data discrepancies with HCPF to resolve these issues and build trust.

The SE Team facilitated a discussion surrounding program sustainability with the following discussion questions posed to DRT participants:

- Are the themes correctly capturing the discussion on program sustainability?
- Is there additional feedback or comments on program sustainability that should be considered when designing PACK?

Questions and feedback from DRT participants are below:

- DRT participants emphasized that trust-building between the Department and providers is essential to a successful PACK program.
    - A DRT participant suggested developing a process metric to demonstrate collaboration among the Department, the practice, and the RAE to discuss attribution, discrepancies, and planning.
    - A DRT participant noted that the model's reliance on claims data assumes trust in HCPF's data quality. They emphasized the need for reciprocal trust between practices and the Department, advocating for confidence in practices' ability to report data accurately.

5. Next Steps

Devin Kepler referred to the PACK roadmap shared at the beginning of the meeting.

He shared that PACK Soft Launch will likely be rolled out between early to mid 2025, given the time and involvement needed to build a data dashboard, but emphasized that payment will **not** be involved, nor will payment with other APMs will be impacted, during this Soft Launch period. He shared that PACK Implementation is currently planned for six to twelve months following soft launch, during which performance on quality measures will be tied to payment, and during which other APMs (e.g. APM 1) will be phased out.

He also reminded DRT participants that priorities following DRT meetings include incorporating DRT feedback into program design through internal design discussions. He specifically noted that there will be intentions to align the PACK program with other initiatives, like ACC Phase III. Devin encouraged DRT participants to stay in communication regarding updates to PACK program design and shared additional opportunities for engagement, which include:

- Public meetings to share PACK model design (and updates on other VBP programs)
- Testing team throughout initial year of PACK where provide and RAEs will meeting quarterly to provide feedback

Questions and feedback from DRT participants are below:

- A DRT participant asked if there would be any incentive payment tied to participation during the Soft Launch period. They expressed concern about administrative burden to participate in PACK Soft Launch without payment.
    - Devin (HCPF) acknowledged concerns about incentive payment not being provided during the Soft Launch period. He noted that budget authority through the state medical board and federal approval is necessary for any pay-for-reporting period.
- DRT participants wondered whether providers participating in APM 1 would lose funding (4% fee-for-service bump) with that program going away.
    - Devin (HCPF) responded that the 4% pay bump would be baked into fee-for-service rates and would not go away with the implementation of PACK.
- Devin and Katie Price (HCPF) informed DRT participants of in-person and hybrid sessions occurring in the next 6-9 months to review the PACK program and address additional questions and comments. Updates will be provided via the PACK webpage; DRT participants were also invited to reach out at any time via email.

Finally, referencing the PACK North Star, Devin Kepler (HCPF) thanked DRT participants for their work and contributions over the past DRT meetings.

- DRT participants thanked Devin and the team for their great partnership from the start and for their efforts in designing a pediatric-specific value based model. They requested that the Department to continue to engage stakeholders with regards to the roll-out of PACK efforts.

Suman then closed the meeting.