COLORADO
Department of Health Care Policy & Financing

Payment Alternatives for Colorado Kids (PACK)
Design Review Team (DRT)
Meeting Minutes
June 26, 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, Andrea Loasby, Cassie Littler, David Keller, Ealasha Vaughner, Erica Pike, Hillary Jorgensen, Hoke Stapp, Jane Reed, M. Cecile Fraley, Mark Gritz, Melissa Buchholz, Mike DiTondo, Rebecca Gostlin, Robert Haywood, Sarah Bennett, and Sarrah Knause.

Other attendees included Britta Fuglevand (Department of Health Care Policy and Financing [HCPF]), Devin Kepler (HCPF), Katie Price (HCPF), Zoe Pincus (HCPF), Breelyn Brigola (Stakeholder Engagement (SE) Team), Emily Leung (SE Team), Suman Mathur (SE Team), Andy Wilson (PACK Support Team), The PACK Support Team (PACK Support Team), The PACK Support Team (PACK Support Team), and Samik Gupta (PACK Support Team).

2. Meeting 8 Recap

Suman Mathur reviewed DRT participant feedback from the DRT 8 Meeting (6/12) on considerations of non-reimbursed pediatric outpatient primary care activities under Fee-for-Service (FFS). She described how additional staffing and financial resources are needed to advance to higher care levels for integrated behavioral health, health related social needs (HRSN) screening, same-day triage and appointment availability, and care coordination. Suman also noted that for HRSN screening, DRT participants suggested there be additional levels between a provider conducting a screening and a member being able to enroll or receive appropriate assistance or services. Barriers to advanced care coordination include a lack of advanced technical infrastructure, as well as challenges navigating existing regulations for information sharing.

Suman then presented DRT Meeting #8 minutes for approval and reminded DRT participants of the PACK North Star Goal. There were no objections to the meeting minutes.

3. Level-Setting

The PACK Support Team framed the discussion around payment and described how a focus on payment considerations for pediatric providers may help inform the three payment- related buckets reviewed in previous DRTs: primary care services, incentive payments, and non-reimbursed activities.

The PACK Support Team also shared the objectives of this DRT meeting:

1. Identify financial barriers that pediatric practices face which may hinder their success in Alternative Payment Models (APMs).
2. Define medically and socially complex factors for pediatric Health First Colorado members aged 0-18.
    - Understand what adjustments could be made to payments to support these populations.

4. Discussion: Considerations for Pediatric Provider and Population Types

The PACK Support Team shared that today's discussion would examine the unique considerations essential to pediatric practices at large, then discuss pediatric practice subtypes (e.g., small and rural), and close out with considerations about pediatric population types (e.g., medically complex and socially complex). The PACK Support Team stated that these practice and population types are not mutually exclusive and acknowledged that all pediatrics may not have the same payment methodology, such as school-based health centers (SBHC), rural health centers, and federally qualified health centers (FQHC).

Presentation and Discussion: Pediatric Practice Considerations

Devin Kepler presented information on considerations for pediatric practices. He defined pediatric practices as practices with more than 80% of the Health First Colorado members served are between 0-18 years of age. He noted that this basis of the definition for pediatric practices came from the Division of Insurance (DOI) Regulation 4-2-96 regarding Primary Care Alternative Payment Model Parameters. He shared some financial barriers experienced by pediatric practices and their impacts on primary care medical provider (PCMP) and member experiences.

- **Financial Barriers:** Low revenue from a high Medicaid payer mix, small panel sizes due to frequent preventative and sick visits, and historical underfunding of cognitive work.
- **Impact to PCMP Experience:** Limiting the ability to hire staff for outreach and care coordination and carrying more financial risk and instability due to high the Medicaid payer mix.
- **Impact to Member Experience:** Limited access to care and reduced provider choices, as well as limited access to patient-centered activities like education, counseling, and care coordination.

The SE Team facilitated a discussion surrounding Pediatric Practice Considerations with the following discussion questions posed to DRT participants:

- Does the definition of pediatric practices align with your understanding or experience?
- Are there additional financial barriers that most pediatric practices experience?
    - If so, how does this affect practice or member experience?

- What resources and support could be provided so that pediatric practices can be successful in PACK?

Questions and feedback from DRT participants are below:

- DRT participants noted that the proposed definition for pediatric practices excludes family medicine practices who play an important role in pediatric care, particularly in rural Colorado.
- A few DRT participants disagreed that pediatric practices have a smaller panel size relative to family medicine offices, with one DRT participant sharing their practice panel size includes 2,000 pediatric members while the standard family medicine panel size is 1,500 patients.
- DRT participants noted that pediatric practices have fewer financial resources because of their reliance on Medicaid, and that they also lack experience with value based payment programs since such experience is primarily a feature of Medicare. Family medicine practices receive higher reimbursements due to caring for more Medicare-enrolled patients, which typically has higher reimbursement rates compared to Medicaid.
    - A DRT participant explained how while larger Medicare payments result in increased reimbursements, practices focused on adult medicine provide access to additional shared savings, which does not apply to pediatric primary care.
- Some DRT participants described how a high Medicaid payer mix, experienced across different practice types including family medicine practices, poses a significant financial barrier, as pediatric practices do not have Medicare or private payers to offset lower Medicaid reimbursement rates.
- DRT participants commented on the low revenue experienced by pediatric practices due to decreased reimbursement rates and increased costs, including overhead costs associated with immunization programs and the limited availability of specialty referrals driving up the total cost of care.
- DRT participants stated that there are fewer pediatric specialists in the state, particularly in rural areas. Pediatric primary care providers resultingly manage more complexity (e.g., integrated behavioral health, registered nurses for vaccine administration, and telephone triage) within their practice compared to adult primary care. This has implications on practice transformation and sustainability.

Presentation and Discussion: Rural Pediatric Practice Considerations

Dr. Price shared financial challenges faced by rural pediatric practices and implications on PCMP and member experiences. She defined rural pediatric practices as pediatric practices (those with more than 80% of the Health First Colorado members served are 0-18 years old) that operate in areas with a total geographic population than 200,000 and where population density is below 100 individuals per square mile. Population size and density thresholds are based on the DOI Amended Regulation 4-3-53 on network adequacy standards and reporting requirements for Affordable Care Act-compliant health benefit plans. She explained that there are five different geographic categories with the classification system (e.g., large metro, metro, micro,

rural, and counties with extreme access consideration (CEAC). For the purposes of this discussion, any populations below 'Micro' classification parameters are considered rural.

- **Financial Barriers:** Instability from unpredictable cash flow, high staffing costs due to a limited recruiting pool, and underfunding from a high Medicaid payer mix.
- **Impact to PCMP Experience:** Limiting the ability to maintain staffing levels, causing disjointed workflows, and leading to provider burnout and increased administrative efforts.
- **Impact to Member Experience:** Delays accessing care, difficulty reaching practices, and inconsistent care due to staff turnover, which may affect trust.

The SE Team facilitated a discussion surrounding Rural Pediatric Practice Considerations with the following discussion questions posed to DRT participants:

- Does the definition of rural pediatric practices align with your understanding or experience?
- Are there additional financial barriers that most rural pediatric practices experience?
    - If so, how does this affect practice or member experience?
- What resources and support could be provided so that rural pediatric practices can be successful in PACK?

Questions and feedback from DRT participants are below:

- A DRT participant asked if rural and CEAC (Counties with Extreme Access Considerations) would be considered frontier or if they are distinct.
    - Dr. Price stated that frontier is a different designation from rural and explained that CEAC is synonymous with frontier.
- DRT participants stated that there is less access to specialty care in rural areas, which results in pediatric primary care practices having to take on more of this in-house (e.g., G-tubes, cardiac, renal complications, and psychosis) and addressing increased mental health needs, a role for which pediatricians are typically not trained.
- Another DRT participant noted there is also less rural access to developmental and early childhood supports, like early intervention or Applied Behavior Analysis (ABA) therapy due to limited funding and staffing.
    - Though an increased mental health need is not specific to rural areas, it is still an added complexity when addressing mental health and psychiatry needs that are often outside of provider training.
- A DRT participant suggested considerations for the definition of rural practices including using the Rural Urban Continuum Codes (RUCC), which are total population based but provide nine (9) different categories based on both population and distance to urban areas. Another DRT participant suggested basing the definition on patient location rather than practice location.
- A DRT participant noted that there are limited referral resources in rural areas to support HRSN, particularly impacting screenings and assessments. Rural

clinics may act as a community resource hub which may increase non-billable services and require extensive staff time to connect patients to necessary services.

Presentation and Discussion: Small Pediatric Practice Considerations

Dr. Price presented financial challenges and impacts on PCMP and member experiences for small pediatric practices. Small pediatric providers are considered independent pediatric practices (those with more than 80% of the Health First Colorado members served are 0-18 years old) who are operating with fewer than five (5) providers.

- **Financial Barriers:** High fixed costs relative to variable costs and revenue, inability to qualify for volume-based incentive payments, and limited access to capital.
- **Impact to PCMP Experience:** Limiting resources, technology, and access to electronic health records, increasing workload and reducing control over work hours, diminishing the ability to manage financial risk, and being less likely to hire care coordinators or engage in quality improvement collaboratives.
- **Impact to Member Experience:** Limited access to patient-centered activities such as education, counseling, and care coordination, as well as reduced access to clinic infrastructure like online portals.

The SE Team facilitated a discussion surrounding Small Pediatric Practice Considerations with the following discussion questions posed to DRT participants:

- Does the definition of small pediatric practices align with your understanding or experience?
- Are there additional financial barriers that most small pediatric practices experience?
    - If so, how does this affect practice or member experience?
- What resources and support could be provided so that small pediatric practices can be successful in PACK?

Questions and feedback from DRT participants are below:

- DRT participants sought clarification on defining small pediatric practices, considering whether to base it on the number of providers or full-time employees (FTEs), with suggestions leaning towards defining small practices as those with fewer than five FTEs due to the complexity of roles and potential for provider burnout in such settings.
    - Given that a practice may have different locations, a DRT participant wondered whether the small practice definition was based on a tax identification number (TIN), an individual national provider identification (NPI), or primary care medical provider (PCMP) site.
- DRT participants proposed considering the mix of payers, provider size, and patient volume as key factors in determining what constitutes a small practice, highlighting the particular challenge of a high Medicaid patient base in such settings.

- DRT participants noted the fewer opportunities for shared savings in small pediatric practices compared to practices focused on adult medicine. A DRT participant shared that their practice receives more significant financial benefits through a commercial plan.
- A DRT participant noted that nearly all of the administrative tasks needed to support the business and engage in value based payment models, fall on a single FTE, thus posing a significant financial and operational burden on staff.
    - Another DRT participant advocated for models to offer the necessary coaching and staffing assistance to allow for small practices to succeed.
- A DRT participant highlighted the financial challenges small practices face, particularly with limited technology and access to advanced electronic health records (EHRs), affecting their ability to effectively utilize reporting features.

Presentation and Discussion: School Based Health Center Considerations

Dr. Price presented on financial challenges that school-based health centers experience and its associated impacts on PCMP and member experiences. According to the Colorado Department of Public Health and Environment, school-based health centers are medical clinics offering health care (including well-child exams, screenings, behavioral health care, and sick visits) to youth in a school or on school grounds.

- **Financial Barriers:** Inconsistent funding across federal and state levels and have high initial setup costs (e.g., expenses for infrastructure, medical equipment, and workforce).
- **Impact to PCMP Experience:** Potential gaps in service provision due to limited administrative capacity and resources, as well as provider burnout and retention from high service demand with inconsistent funding.
- **Impact to Member Experience:** Limited hours or availability and limited access to a wide breadth of supportive specialty care services, including behavioral health.

The SE Team facilitated a discussion surrounding School Based Health Center Considerations with the following discussion questions posed to DRT participants:

- Does the definition of school based health centers align with your understanding or experience?
- Are there additional financial barriers that most school based health centers experience?
    - If so, how does this affect practice or member experience?
- What resources and support could be provided so that school based health centers can be successful in PACK?

Questions and feedback from DRT participants are below:

- DRT participants highlighted the diverse affiliations and lack of formal certification for school-based health centers (SBHCs) in Colorado, leading to

financial strains due to stagnant and inadequate state funding despite their expansion.
- They noted the convenience of SBHCs for immediate care but mentioned challenges in being recognized as medical homes and in providing well-child visits if the child is already attributed to a primary care provider.
- Other considerations for SBHCs include the importance of confidential care and the push for integrated behavioral health services, which introduces staffing challenges and complicates data accuracy.
    - DRT participants discussed Children's Hospital BC4U program, a Title 10 clinic, offering confidential services such as IUD placements and complex contraception options, even for those with private insurance.
- Challenging dynamics and coordination with schools and school boards, as well as grant reporting tasks, add additional administrative burden and costs for SBHCs.

Discussion: Other Distinct Pediatric Practice Types

Suman Mathur then facilitated a discussion about other distinct subsets of pediatric practices for consideration. The discussion question posed to DRT participants was:

- Beyond rural, small, and school-based health center practice types, are there other distinct subsets of pediatric practices that face unique financial challenges? Why?

Questions and feedback from DRT participants are below:

- A DRT participant reiterated specific resource allocation challenges of family practices that simultaneously focus on adult and pediatric metrics. They particularly cited that FQHCs, in particular, have recently prioritized adult metrics due to the challenges of focusing on both simultaneously.
- Clinics that care for a large foster youth population are worth considering a distinct pediatric practice type.

Presentation and Discussion: Considerations for Members: Medical Complexity for Pediatric Members

Andy Wilson shared information on defining medically complex pediatric members in data. He identified four risk factors, which include disability status, conditions, behavioral health and utilization. Associated definitions and categories are below.

- Disability Status: A qualifying disability, either through Social Security or the State Disability Determination vendor
- Conditions: Members with the following conditions, organized by three types
    - Common Conditions: asthma, allergies, eczema, reactive airway disease, developmental delays, obesity
    - Less Common Conditions: cancer, diabetes, technology-dependent children
    - Newborn Conditions: congenital malformation, genetic, metabolic, premature babies (32 weeks or less)

  - Behavioral Health: Members with behavioral health conditions (anxiety, attention hyperactivity disorder, autism spectrum disorder, depression, substance use disorder)
  - Utilization: Number or urgent care visits, emergency department visits, admissions, and crisis encounters

The SE Team concurrently facilitated a discussion surrounding Medically Complex Pediatric Members. Discussion questions posed to DRT participants were:

- What other factors should be considered when defining medically complex pediatric members?
- Are there additional common pediatric-specific conditions or characteristics that contribute to medical complexity in pediatrics?
- What are the challenges with identifying these medical factors that characterize medically complex pediatric members?

Questions and feedback from DRT participants are below:

- DRT participants requested clarification on whether the definition of medical complexity in pediatric patients was for payment reasons or to help practices risk stratify for care coordination.
  - Andy (PACK Support Team) responded that the discussion is focused on the context of payment but encouraged a broad framing of medical complexity.
- DRT participants shared that just the presence of a condition or diagnosis is not sufficient for a definition of medical complexity in pediatrics. They suggested a more nuanced definition accounting for number of visits, or how a condition can ebb and flow.
  - Some resources which DRT participants referenced during the discussion include:
    - A resource from the American Academy of Pediatrics (AAP) which offers insights into standardizing medical complexity
    - The Pediatric Medical Complexity Algorithm (PMCA) from Seattle Children's Hospital in Washington, which assesses medical complexity through a condition-based measure also integrating a behavioral health component
    - AAP's June edition on the clinical definition of pediatric medical complexity.
- DRT participants suggested adding pediatric members who are receiving home care services, such as through a Home and Community-Based Services (HCBS) waiver, to the medical complexity definition.
- DRT participants stated the importance of developing a practical and meaningful definition of complexity specifically from a pediatric perspective, acknowledging that existing state definitions do not adequately address the unique needs of children.
- DRT participants stated that pediatric medical complexity cannot be solely condition-specific, using asthma as an example, and emphasized the need for a complexity definition that reflects the broad range of pediatric care needs.

- DRT participants stated that health-related social needs and the varying abilities of families to manage pediatric medical conditions should be included as factors in the risk assessment for medical complexity.
- DRT participants stated the significance of defining medically complex individuals accurately, exploring the use of a claims-based approach like the Pediatric Medical Complexity Algorithm (PMCA) for this purpose.
- DRT participants debated as to whether disability status should be an indicator of complexity, with some sharing that it is more nuanced than just being on disability and one in favor of its inclusion, as the current determination of disability status is larger and more diverse than the Supplemental Security Income (SSI) criteria.
- DRT participants stated the necessity of addressing the needs of youth with complex conditions in rural areas, including coordination with specialists for treatments and the challenges of providing comprehensive care in these settings
- DRT participants stated the importance of discussing the transition of medically complex patients from pediatric to adult care, highlighting the significant effort and resources required to ensure a smooth transition for these patients

Presentation and Discussion: Considerations for Members: Social Complexity for Pediatric Members

The PACK Support Team presented information on defining socially complex pediatric members in data. There are five risk factors, including education and literacy; physical and social environment; housing and economic circumstances; upbringing and primary support group; and psychosocial circumstances. The PACK Support Team explained that the definitions or categories are based on Z-codes from the Centers for Medicare and Medicaid Services. Associated definitions and categories are below.

- Education and Literacy: Problems related to education and literacy (Z55)
- Physical and Social Environment: Problems related to physical environment (Z58) and social environment (Z60)
- Housing and Economic Circumstances: Problems related to housing and economic circumstances including homelessness, inadequate housing, and food, transportation, and financial insecurity (Z59)
- Upbringing and Primary Support Group: Problems related to upbringing including upbringing away from child abuse, parent-child conflict, non-parental relative or guardian-child conflict, runaway (Z62), and problems with primary support group (Z63)
- Psychosocial Circumstances: Problems related to psychosocial circumstance (Z64 and Z65)

During this presentation, the SE Team facilitated a discussion about Socially Complex Pediatric Members. Discussion questions posed to DRT participants were:

- Are there other prevalent social factors influencing health outcomes that should be incorporated into the definition of socially complex pediatric members?

- What are the challenges with identifying these social factors that characterize socially complex pediatric members?

Questions and feedback from DRT participants are below:

- A DRT participant stated early relational health should be considered in defining pediatric social complexity.
- DRT participants shared their experiences with using Z-codes, and suggested caution when using them, given that there is slow uptake, denials for billing, and a maximum number that can be used for a claim.
    - A DRT participant shared that their practice chooses three vague codes, none of which fall into the ones under the current definition for social complexity.
    - DRT participants stated that Z-codes are not widely utilized, and identifying complexities in pediatric care will likely necessitate direct data collection and reporting by practices, which could increase practice costs.
    - A DRT participant pointed out there may be some practices that face challenges around shame or stigma with Z-codes.
- A DRT participant highlighted some challenges with social needs screening, including privacy concerns and inconsistent reporting.
- DRT participants stated the need for clarification on the inclusivity of Z-code subcodes and the importance of considering family stability as part of social complexity, recognizing that changes in family dynamics, including separation or divorce, significantly impact a child's life and should encompass extended family members.

<u>Discussion: Other Distinct Pediatric Populations Served by Pediatric Practices</u>

Suman Mathur then facilitated a discussion about other distinct pediatric populations served by pediatric practices for consideration. The discussion question posed to DRT participants was:

- Beyond medically and socially complex pediatric populations, are there other distinct pediatric populations that should be considered for PACK?

Questions and feedback from DRT participants are below:

- DRT participants suggested considering increased transient populations and newcomer families as other distinct pediatric populations served by pediatric practices, emphasizing the need for different treatment approaches to effectively address their needs without negatively impacting performance metrics.
- Similar to confidentiality concerns with respect to school-based health centers, confidentiality in the integrated behavioral health realm should be considered within complex populations.

5. Looking Ahead

Suman Mathur provided a list of resources and reminded DRT participants about the next meeting on July 10 from 5-7pm, during which considerations for special provider types and populations will be discussed. Suman then closed the meeting.