COLORADO
Department of Health Care Policy & Financing

Payment Alternatives for Colorado Kids (PACK)
Design Review Team (DRT)
Meeting Minutes
March 27, 2024
5:00 P.M. to 6:30 P.M.

1. Introductions

Suman Mathur called the meeting to order.

The following DRT participants were in attendance: Alison Keesler, Amber Griffin, Andrea Loasby, Cassie Littler, David Keller, Hillary Jorgensen, Hoke Stapp, Jane Reed, M. Cecile Fraley, Mark Gritz, Melissa Buchholz, Mike DiTondo, Robert Haywood, Sarah Bennett, Sarrah Knause, and Toni Sarge.

Other attendees included Devin Kepler (HCPF), Katie Price (HCPF), Matt Lanphier (HCPF), Peter Walsh (HCPF), Emily Leung (Stakeholder Engagement (SE) Team), Suman Mathur (SE Team), Andy Wilson (PACK Support Team), Puja Patel (PACK Support Team), and Samantha Block (PACK Support Team).

2. Attribution

Emily Leung highlighted that attribution is the main priority for today's discussion and explained that today's meeting is primarily informational.

Suman Mathur provided background on the ACC and explained that we are currently in ACC Phase II, which began in July 2018, and that Phase III of the ACC will begin in July 2025. Suman also noted that, although there are changes to be implemented at the beginning of ACC Phase III, there will also be other performance improvement processes occurring in the future, throughout the next phase.

Matt Lanphier provided background on what attribution is and why attribution is important. Specifically, accurate attribution (e.g., determination of the relationship between a member and provider) is critical to a value based payment model. Matt discussed the four methods of attribution in ACC Phase II. These are utilization, family connection, geographic, and member choice. Matt explained that there is a funnel approach, where utilization is assessed first, and then family connection and geography are considered. However, member choice takes preeminence above other types of attribution. Matt noted that reattribution is currently determined every month for pediatric members between the ages of 0 and 2 and every six (6) months for all other members.

- A DRT participant asked how long a member must be on Medicaid before becoming attributed, and specifically wanted clarification about new members and attribution via utilization.

    - Staff responded that new members are attributed as soon as the Department receives the member's eligibility from the Colorado Benefits Management System (CBMS). Newly enrolled members will not have claim history, and therefore will be attributed upon enrollment via family connection or geographic methodology. If a member loses Medicaid and regains eligibility within 60 days, the member will be automatically reattributed to the previous Primary Care Medical Provider (PCMP). Members who lose eligibility for 60 days or more will be attributed as a newly enrolled member.

Matt Lanphier discussed changes to attribution methodology from Phase II and Phase III. Matt discussed the decision to eliminate geographic attribution and attribution based on family connection. Matt noted the challenges with geographic attribution and estimated that less than five (5) percent of members developed a claims history to their geographically attributed with to the to a PCMP. Matt noted that rationale for removal of family connection was similar and noted that there were technical challenges with the process of determining family connection.

Matt also discussed the modifications to attribution via utilization that will occur in ACC Phase III. Specifically, he noted that utilization based attribution will be determined by a prioritization of the two most recent claims with a PCMP by first examining the evaluation and management (E&M) claims and then other claim types. Matt noted that a subset (e.g., 10 preventive service codes) of E&M claims for children up to age 21 will be prioritized. Matt noted that reattribution via utilization will run monthly for members who are unattributed. He also highlighted reattribution will continue to be determined every month for pediatric members between the ages of 0 and 2 but will occur every three (3) months for all other members.

DRT participant questions and staff responses are summarized below:

- A DRT participant inquired about whether there is a ratio for preventive service codes used in pediatric attribution versus all E&M codes. They requested clarification on whether two (2) E&M claims trump one (1) preventative claim.

    - Staff responded that preventive service claims are prioritized for children under 21 as the methodology that assumes the provider who is providing preventive care is the best reflection of who the member considers to be their PCMP. The rationale to change the utilization based attribution methodology to the most two (2) recent claims is to

capture member moves more accurately than we otherwise would under the current methodology. Whether those two (2) most recent claims trump the preventative claim is a policy question that is yet to be determined.

- A DRT participant asked whether providers are notified if their patients become reattributed to a different provider.
    - Staff noted that the member would be removed from the providers' roster in the Attribution Insights Tool via data analytics portal (Merative/IBM), which will allow providers to identify whether members are receiving care elsewhere.
- A DRT participant asked whether HCPF would consider using active claims to reattribute members who had initially chosen a different provider via member choice.
    - Staff shared that in ACC Phase III, member choice will still be prioritized but member choice would have an "expiration date" of 18 months.
- Some DRT participants asked whether attribution and reattribution would continue to use Section 32 of the claim, which identifies service location and clinic National Provider Identifier in ACC Phase III. Information was requested on whether this process would apply to both Federally Qualified Health Centers (FQHCs) and non-FQHCs.
    - Staff explained that attribution will be done at the PCMP ID level for both FQHCs and non-FQHCs.
- A DRT participant wondered whether using the two most recent visits is the best approach, as members may switch locations within the same health system.
    - Staff responded that the goal of the utilization based attribution change to the most recent visits is to increase accuracy. HCPF has completed analyses on determining the two (2) most recent visits is appropriate, and that while attribution at a high-level has been finalized, HCPF is open to more specific changes on the attribution methodology and is not married to the two (2) most recent visits.
- A DRT participant shared that the number of acute or non-preventive services may be different in younger children versus older children or adolescents.

- A DRT participant asked how HCPF plans to address the potential negative impacts on access if a provider in a prospective payment model does not schedule a member that is not attributed to them.

- A DRT participant inquired about the Denver Health Medical Plan (DHMP) assignment in ACC Phase III, noting that this is a significant consideration of attribution and pointing out that passive enrollment into DHMP can affect continuity of care and member choice.

    - Staff noted that there is a statutory requirement that requires HCPF to offer DHMP and shared that HCPF is exploring ways to improve the newborn and passive enrollment procedures in ACC Phase III.

- Some DRT participants suggested having a continuous feedback loop between HCPF and providers, where providers can request amendments to the attribution roster for non-active members in their practices.

    - Staff shared that HCPF wants to ensure there is a simple and transparent attribution methodology, while also working to increase the accuracy and timeliness of attribution changes. Staff noted that HCPF does not have the technological capabilities at this time to reconcile differences between PCMPs' rosters and HCPF's roster.

- A DRT participant suggested aligning attribution across all HCPF programs, such as Alternative Payment Model (APM) 1 & APM 2.

3. Attribution Discussion

Suman Mathur led an open-floor discussion, facilitated by an exercise for DRT participants to reflect on the proposed Phase III attribution methodology and its implications on the PACK program.

The discussion questions guiding DRT participant feedback were:

- Menti Poll – On a scale of 1 (not at all clear) to 5 (very clear): how clear is the proposed Phase III methodology to you?

- What aspects of the proposed Phase III methodology do you find unclear?

- What aspects of the proposed Phase III methodology do you appreciate?

- What are potential unintended consequences of the Phase III approach?

- Menti Poll – On a scale of 1 (not at all clear) to 5 (very clear): will the proposed "two (2) most recent PCMP visits" reattribution approach update member attribution in a more accurate and timely way?

DRT participants' reactions to the ACC Phase III Proposed Utilization Methodology (2 Most Recent PCMP Visits) are below:

- When asked on a scale of 1 (not at all clear) to 5 (very clear) how clear the proposed Phase III methodology is, the average score was 3.8.

- A DRT participant shared that a child's age will impact whether the proposed utilization approach (using 2 most recent PCMP Visits) improves accuracy and timeliness, young children frequently come in for acute care visits and their PCMP may not always have same day acute visits. Another DRT participant agreed with the suggestion to identify how many acute visits are equivalent to preventive visits in the proposed utilization approach.

General comments to the ACC Phase III Proposed Attribution Methodology are below:

- When asked from a scale of 1 (not at all clear) to 5 (very clear) if the proposed "two (2) most recent PCMP visits" reattribution approach will update member attribution in a more accurate and timely way, the average score was 3.1.

- DRT participants emphasized the challenges of provider attribution due to patients transitioning between care sites and suggested an attribution process that accounts for this.

- DRT participants expressed concern about whether the proposed attribution methodology would accurately reflect the true provider-member relationships, as it can be challenging to determine a member's main primary care provider. A DRT participant emphasized mostly being concerned with seeing consistency in attribution.

- DRT participants expressed concerns about the potential decrease in the number of attributed members to practices due to the new attribution methodology. This could particularly affect smaller, independent practices incapable of easily managing revenue stream fluctuations.

- A DRT participant noted that until there is a way to increase reimbursement for pediatrics, there is still going to be a continuation of loss of pediatric providers in medicine, drawing to light the decline in pediatric residency matches and difficulties hiring pediatricians.

- DRT participants also shared that an unintended consequence of the proposed attribution model could be low uptake of a prospective payment option.

- DRT participants requested clarity on reimbursement for members ages 19 and above, not included in the PACK program but seen by pediatric practices. They stated this typically includes those aged 19-26, often seen in family medicine or those with special conditions (e.g., Autism or Down Syndrome) that require extended time and care coordination. DRT participants expressed financial concerns for these pediatric practices serving ages 19-26, requesting that reimbursement rates should be at least equivalent to those for PACK-eligible members aged 0-18.

    - Staff responded that practices who serve patients between 19-26 years of age would be paid fee-for-service in the PACK model.

- A DRT participant wondered why providers do not have more of a role in choosing which patients are attributed to them in the proposed methodology, as currently done in Rocky Mountain Health Plans PRIME for adult practices.

- A DRT participant asked whether there would be a more accessible way for members to change their PCMP rather than calling their enrollment broker, noting that the current process is challenging and time-consuming for members who have little incentive to do this.

- A few DRT participants expressed appreciation for the removal of geographic attribution in ACC Phase III as it lightens provider burden.

4. Meeting 3 Recap

Given time constraints from the last meeting, Katie Price presented information on Goal 6 of the PACK model. She highlighted that the pediatric-specific practice transformation objective was moved from Goal 2 (Improve developmental and behavioral outcomes for child and adolescent members) to Goal 6. For feedback on Goals 1-5, refer to PACK DRT Meeting 3 minutes.

Goal 6. Develop a pediatric VBP program that is sustainable for both providers and HCPF.

- Objective: Improve pediatric provider and practice staff experience

- Objective: Minimize provider administrative burden

- Objective: Create model design which is operationally efficient and financially sustainable for both HCPF & providers

- Objective: Provide health information technology tools for PCMPs that provide actionable insight into performance
- Objective: Increase adoption of pediatric-specific practice transformation in all primary care settings that care for child and adolescent members
- Associated Measures (Informational Only): To be determined

DRT participants' reactions, organized by objective, are below:

- A DRT participant confirmed that none of these objectives would be tied to payment for providers and represent more system-level objectives.
    - Staff responded that HCPF is thinking about informational, programmatic measures for this goal.
- Objective: Improve pediatric provider and practice staff experience
    - DRT participants suggested the following measures:
        - Trends in member enrollment and disenrollment by provider
        - Member attribution trends by provider
        - Provider and practice staff satisfaction surveys
- Objective: Minimize provider administrative burden
    - Some DRT participants cautioned HCPF from including additional measures, such as provider surveys, that would contradict the objective under this goal of minimizing provider administrative burden. However, some DRT participants pointed out that providers may be willing to take on administrative burden if the program is providing adequate resources and providers are benefitting.
- Objective: Provide health information technology tools for PCMPs that provide actionable insight into performance
    - A DRT participant suggested a measure to monitor tool usage.
- Objective: Increase adoption of pediatric-specific practice transformation in all primary care settings that care for child and adolescent members
    - DRT participants noted practice transformation services for PACK should be pediatric-specific and emphasized the need to offer

resources for practices and providers to incentivize practice transformation.

- A DRT participant wondered what the minimum amount of information would be to justify the PACK program and measure success.

5. Looking Ahead

Suman Mathur presented DRT Session #3 meeting minutes for approval, which DRT participants approved.

She also thanked DRT participants for sharing their feedback and reiterated her invitation to share any questions or comments on attribution with the SE Team, who would pass along their feedback to Matt Lanphier. Suman then closed the meeting.