COLORADO
Department of Health Care Policy & Financing

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

May 8, 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 Keesler, Amber Griffin, Andrea Loasby, Cassie Littler, Ealasha Vaughner, Hillary Jorgensen, Hoke Stapp, Jane Reed, M. Cecile Fraley, Mark Gritz, Melissa Buchholz, Robert Haywood, Sarah Bennett, Sarrah Knause, and Toni Sarge.

Other attendees included Devin Kepler (Department of Health Care Policy and Financing [HCPF]), Katie Price (HCPF), Britta Fuglevand (HCPF), Helen Desta-Fraser (HCPF), Breelyn Brigola (Stakeholder Engagement (SE) Team), Emily Leung (SE Team), Suman Mathur (SE Team), Andy Wilson (PACK Support Team), and Puja Patel (PACK Support Team).

Suman explained that the objectives for today's meeting were to level-set on the PACK design scope and working assumptions, introduce considerations for PACK payments and examples of payment design elements, and gather feedback on payment mechanisms and a pay-for-performance model.

Emily Leung presented DRT Session #5 meeting minutes for approval, which DRT participants approved. Emily also reminded DRT participants of the PACK North Star Goal, and Suman referenced the six PACK Goals (see Meeting #2 deck for a list of PACK goals) that guide the design process for PACK. Suman stated that considerations for possible payment mechanisms for PACK was the priority for today's discussion.

2. PACK Design Scope

Devin Kepler reminded DRT participants that PACK is a value based payment model for Primary Care Medical Providers (PCMPs) for the primary care services they provide to child and adolescent members (0-18 years of age) in the primary care setting. He also acknowledged that PACK payment design may evolve with potential alignment with other initiatives such as Affordable Care Collaborative (ACC) Phase III and Integrated Behavioral Health. Implementation of incentive payments is also dependent on processes that are potentially outside of HCPF jurisdiction (i.e., Joint Budget Committee (JBC) and State Plan Amendment (SPA) approval and budgeting).

Questions and feedback from DRT participants are below.

- DRT participants wondered if children being added to Medicaid with Cover All Colorado in 2025 (House Bill 22-1289) will also be eligible for PACK. The Cover All Colorado program provides coverage even to children who, due to their immigration status, might otherwise be ineligible for Medicaid at the federal level.
    - HCPF responded that the Department will look into it further, but that if children are included in Health First Colorado, then they are likely to be included in PACK.

Based on previous stakeholder discussions, HCPF is considering not including shared savings, Total Cost of Care (TCOC), or downside risk models for the initial phase of PACK, as they have heard that these model options are not appropriate for pediatric primary care. Devin presented information on each of these model options and explained that the purpose of this part of the session was to understand participant's perspective on if there is a place for shared savings, TCOC or downside risk models within pediatric populations.

Shared Savings and TCOC Models. Devin explained that there is an emphasis on cost-efficiency and are in place if primary care services are provided below the financial benchmark, while maintaining or improving performance on quality measures. Suman then shared prior stakeholder feedback on reasons shared savings and TCOC models don't work for pediatric primary care due to high demand for preventative pediatric care, upfront investments, and focus on preventative care. The SE Team invited DRT participants to reflect on whether shared savings and TCOC models make sense for the initial phase of PACK.

Shared Savings and TCOC Models. Questions and feedback from DRT participants are below:

- On a scale of 1-5 (1 being strongly disagree, 5 being strongly agree). Do you agree/disagree that shared savings and TCOC make sense as a payment mechanism for pediatric primary care?
    - *Feedback from DRT participants:* DRT participants generally disagree that shared savings and TCOC models make sense as a payment mechanism for pediatric primary care (average score: 2; n=13).
- On a scale of 1-5 (1 being strongly disagree, 5 being strongly agree), do you agree/disagree that shared savings and TCOC supports the PACK goals?
    - *Feedback from DRT participants*: DRT participants generally disagree that shared savings and TCOC models support the PACK goals (average score: 2.5; n=13).

- Do you have additional considerations for the inclusion or exclusion of shared savings or TCOC in PACK?
    - Feedback from DRT participants:
        - DRT participants outlined several reasons why shared savings/TCOC models are not applicable for pediatric primary care including:
- Limited Opportunities for Savings: The likelihood of generating significant savings in pediatrics is low due to minimal avoidable hospitalization or emergency department (ED) utilization. Pediatric care does not typically involve high-cost interventions that shared savings models benefit from.
- Impact of Acute Illnesses: Acute illnesses like Respiratory Syncytial Virus (RSV) can suddenly increase care requirements, negating any potential savings from reduced ED utilization.
- Behavioral Health as an Exception: While there might be an opportunity for shared savings in behavioral health, it's challenged by the current provider shortage in this area.
- Patient Access Concerns: A shared savings model might negatively impact patient access to providers, especially in managing sudden or acute illnesses and dealing with vaccine hesitancy among parents.
- Long-term Nature of Cost Savings: Cost savings in pediatrics often manifest in the long term and in systems outside of health (e.g., education, child welfare), making it difficult to justify a shared savings model that relies on immediate financial returns.
- Focus on Prevention and Health Promotion: Pediatric care emphasizes prevention and health promotion, especially in early years, which requires more investment upfront without immediate savings.
- Challenges in Measuring Cost Savings: The benefits of preventive measures and addressing vaccine hesitancy may yield long-term payoffs but do not result in short-term savings.
- Small Segments of the Population: While certain pediatric populations could potentially benefit from a TCOC/shared savings model, they represent too small a percentage of the overall pediatric population to justify the complexity and focus of these models.
- Incompatibility with PACK Program Goals: Shared savings models align more closely with chronic disease management and reducing avoidable hospital utilization, whereas the PACK program focuses on long-term savings from preventative care, such as annual wellness visits and vaccines.
- A DRT participant suggested that the Department monitor TCOC as PACK gets introduced to assess long-term savings.

Upside vs. Downside Risk Models. Devin defined the differences between upside risk versus downside risk, stating that upside risk encourages high quality care without getting penalized while downside risk means that providers risk financial losses if quality measures aren't met. Suman shared

that HCPF has heard from stakeholders that downside risk models may discourage pediatric practices from accepting Medicaid patients, which limits access to care. The SE Team similarly invited DRT participants to confirm whether staff understanding regarding perceptions of downside risk models is correct.

Upside vs. Downside Risk Models. Questions and feedback from DRT participants are below:

- On a scale of 1-5 (1 being strongly disagree, 5 being strongly agree): do you agree/disagree that downside risk makes sense as a payment mechanism for pediatric primary care?
  - *Feedback from DRT participants:* DRT participants generally disagree that a downside risk model makes sense as a payment mechanism for pediatric primary care (average score: 2.4; n=10).
- On a scale of 1-5 (1 being strongly disagree, 5 being strongly agree): do you agree/disagree that downside risk supports the PACK goals?
  - *Feedback from DRT participants:* DRT participants generally disagree that a downside risk model supports the PACK goals (average score: 2.4; n=10).
- Are there scenarios where downside risk would make sense? Do you have additional considerations for the inclusion or exclusion of downside risk in PACK?
    - Feedback from DRT participants:
        - DRT participants outlined several reasons why downside risk models are not applicable for pediatric primary care including:
        - Limited Experimentation Opportunities: Pediatric primary care practices, unlike their adult counterparts, haven't had the chance to experiment with risk models due to the lack of pediatric-specific models.
        - Concerns Over Impacting Existing Reimbursements: Any model that potentially impacts the 4% reimbursement increase given to primary care through the Affordable Care Act is viewed as a downside risk, especially if it affects Fee-For-Service (FFS) payments.
        - Challenges in Managing Downside Risk: Success in a downside risk model requires ongoing data analysis and adjustments to mitigate inefficiencies, capabilities that not all practices possess.
        - The Importance of Controllability: Designing downside risk models around controllable factors is crucial, as managing outcomes like immunization rates can be challenging with vaccine-hesitant populations.
        - Dependency on Upside Risk Feasibility: The viability of a downside risk model in pediatrics depends on the structure of the upside risk, with concerns that small

upside risks may not justify the potential access limitations posed by downside risks.
- Uncertainties Around Financial Modeling: There's a need for comprehensive financial modeling to ensure that the potential gains from upside risks sufficiently outweigh the losses from downside risks.
- Balancing Risk and Care Quality: Ensuring that downside risk models do not incentivize practices to compromise care quality, such as avoiding necessary emergency care to mitigate financial penalties.

3. Presentation and Discussion on Potential PACK Payment Methodology

Andy Wilson shared five considerations for PACK payment:

1. Payments should support Program goals.
2. Payments should be rightsized to account for potential underuse of care or to support necessary resources for meeting member needs (social, geographic, equity, etc.) when appropriate.
3. Payments should support cash flow and income predictability.
4. Payments should be adjusted based on clinical and health-related social needs factors *when appropriate.*
5. Payments should use an attribution approach that aligns with care consumption patterns and encourages accurate responsibility across the entire continuum of care *when appropriate.*

Suman Mathur facilitated a conversation surrounding payment considerations and asked DRT participants which considerations resonated the most with individuals, if there were any considerations that were missing, and if modifications should be made. DRT participant questions and comments are summarized below:

- DRT participants suggested including adding considerations on promoting high value care and emphasizing member-centric language.
- DRT participants expressed concern about risk adjustment given the lack of existing pediatric-specific models for risk adjustment (Consideration #4: Payments should be adjusted based on clinical and health-related social needs factors when appropriate). A DRT participant pointed out that many pediatricians are unfamiliar with the processes needed for accurate risk adjustment, potentially leading to underestimation of the real risk profile of their patient population.
    - Staff acknowledged these concerns, emphasizing that appropriate measures are considered in evaluating risk in the population.
- A DRT participant inquired if the geographic accessibility of pediatric services is accounted for in the program considerations, as their practice offers many services due to the lack of nearby facilities.

  - Staff confirmed that geography was factored into Consideration #2 (Payments should be rightsized to account for potential underuse of care or to support necessary resources for meeting member needs (social, geographic, equity, etc.) when appropriate.).

Andy presented information on the overall payment design components and highlighted that some of these considerations may be applicable depending on which payment mechanisms are utilized. Primary care services include payment for the Alternative Payment Model (APM) 2 code set, while incentive payments are contingent on meeting standards for the six (6) DOI Pediatric Measures. He stated that today's discussion around payment would focus on how to pay for pediatric primary care services, referencing FFS partial prospective payment (blended model between FFS and prospective payment), and prospective payment as potential options.

- Fee-For-Service (FFS):
  - Providers are paid for each individual service rendered
  - Payments are based on type, quality, and complexity of services
  - Direct link between number of services and payment
- Partial Prospective Payment:
  - Providers receive a fixed payment (based on predetermined rates) for providing care
  - Prospective payments are advance payments for **some** of the FFS revenue that a PCMP would have received for acceptance of a partial prospective payment for the APM 2 code set
  - Reconciliation occurs for prospective payments back to the FFS claims
- Prospective Payment:
  - Providers receive a fixed payment (based on predetermined rates) for providing care
  - Prospective payments are advance payments for **all** of the FFS revenue that a PCMP would have received for the acceptance of a full prospective payment for the APM 2 code set
  - Reconciliation occurs for prospective payments back to the FFS claims

Questions and feedback from DRT participants are below.

- A DRT participant inquired about the timeframe for reconciliation, suggesting that an annual basis may be too lengthy.
  - Staff acknowledged the concern, noting that reconciliation could potentially occur every 6 months or quarterly, recognizing that a year might be too extended.
- A DRT participant sought clarification on whether full reconciliation implies reimbursing the full FFS claim, questioning if providers are

compensated as per FFS, with prospective payments adjusted accordingly.
    - Staff explained the advantage of prospective payments is providing a predictable, upfront cash flow, allowing providers flexibility in usage without being restricted by monthly billing cycles. This approach aims to address liquidity issues inherent in FFS models but raises questions about its effectiveness in meeting program goals and the mechanism for handling overpayments.
- Another DRT participant expressed interest in understanding the reconciliation process, especially considering challenges like the Public Health Emergency unwind and maintaining Medicaid enrollment for children.
    - Staff acknowledged these concerns as significant and committed to exploring relevant examples.

Andy then presented two hypothetical examples to demonstrate payment options (e.g., FFS and prospective payment) for pediatric primary care services.

1. Example Scenario 1: Practice X (1,500 members) performs 2,100 established preventative visits, 1,500 office visits, 550 depression screenings of which 200 were positive and require follow up. The total FFS payment is $312,326. Practice X decides to take 100% prospective payment at $18 Per-Member-Per-Month ($324,000). During reconciliation, since there are higher prospective payments than the services billed, Practice X is able to keep the additional money above and beyond billed services (e.g., $11,674) pending meeting quality requirements.
2. Example Scenario 2: Practice X (1,500 members) performs 2,100 established preventative visits, 1,800 office visits, 550 depression screenings of which 200 were positive and require follow up. The total FFS payment is $334,532. Practice X decides to take 100% prospective payment at $18 Per-Member-Per-Month ($324,000). During reconciliation, since there are lower prospective payments compared to the FFS services billed, HCPF would pay Practice X the difference between their received prospective payment and billed services (e.g., $10,532).

Questions and feedback from DRT participants are below.

- DRT participants raised concerns about how quality metrics affect reconciliation and prospective payments.
    - Staff clarified that meeting quality metrics is generally assumed with prospective payments but detailed in the reconciliation process.

    - A DRT participant expressed confusion over the scenario examples, advocating for incentive payments to be independent of reconciliation outcomes to ensure practices can earn incentives regardless of being overpaid or underpaid.
    - A DRT participant highlighted the complexity of reconciling prospective payments with quality incentive payments, stressing the need for a clear distinction between the two to avoid discouraging patient care.
    - Staff clarified that incentive payments, aimed at rewarding quality, are separate from other forms of payment, attempting to delineate between payment for services and incentives for quality care.
- DRT participants questioned how new patients are accounted for in payment calculations, highlighting the importance of maintaining incentives for accepting new patients.
- A DRT participant asked about the basis of the per-member-per-month (PMPM) rate and its relation to expected FFS reimbursement.
    - Staff confirming the PMPM rate would be based on past experience and incentive payments are additional.
- DRT participants raised concerns about the potential for prospective payment models to discourage providers from accepting acute visits, especially during high-demand periods like flu or RSV seasons, due to incentives for reducing such visits.
- A DRT participant suggested adjusting the PMPM rate for younger patients emphasizing the necessity of not incentivizing reduced patient care.
- DRT participants raised questions about the sustainability of revenue under the PMPM model based on historical patterns, with considerations for fluctuating patient care needs year over year.
- A DRT participant referenced the Primary Care First model with Centers for Medicare & Medicaid Services model, wherein prospective payments are made on Evaluation and Management (E&M) codes and reconciled through future PMPM payments, emphasizing the upside-only risk model separate from the prospective payment model.
- A DRT participant shared concerns about the feasibility of prospective payments for practices with a significant Medicaid patient mix, emphasizing the reliance on weekly FFS payments and the complexity of transitioning to a prospective payment model.

The SE team facilitated a discussion about prospective payment for pediatric primary care services. Guiding discussion questions included:

- In what scenario would prospective payment make sense?
- What are the unintended consequences of a prospective payment?
- How would a prospective payment help/hurt your cash flow?
- If prospective payments don't make sense for your practice, what does (e.g., FFS)?

- Would receiving prospective payment change how you practice medicine or how practices provide care?

Questions and feedback from DRT participants are below.

- A couple DRT participants noted PMPM rates are based on historical performance (what a practice did two years ago). Implications include:
  - Practices could "win" one year and gain revenue only to easily lose it the next depending on patient care patterns
  - PMPM rates may not account for additional funds for current new efforts like integrated behavioral health or care coordination within a practice
- A DRT participant shared that a prospective payment model may not allow for as predictive cash flow as weekly FFS Medicaid payments and therefore is not a good option for practices that depend on weekly cashflow.
- Another DRT participant appreciated having a hybrid model, if attribution is correct, of having predictable, fixed prospective PMPM and FFS payments that account for additional services (e.g., care coordination and behavioral health) and seasonality.
  - Other participants shared implications of seasonality (ex: flu) and noting the challenge of maintaining the quality of care during high RSV seasons due to staffing limitations, which impacted well-care visit rates and subsequently, quality metrics.
  - A DRT participant suggested increasing the PMPM amount for younger ages (less than 2 years old) to account not only for higher frequency of well care visits, but also for acute services (e.g., RSV).
  - A DRT participant described that a hybrid FFS-prospective payment model could serve as a ramp up period to support pediatric practices new to value-based payment (VBP) models.
- DRT participants cautioned that prospective payment may cause additional administrative burden due to:
  - Full reconciliation processes
  - Broader infrastructure challenge of on-ramping for electronic health records (EHRs) given that billing systems may not have adequate tracking capabilities
- DRT participants raised concerns about the attribution update frequency under a prospective payment model, noting the low incentive to accept new Medicaid patients due to delayed reimbursements and the significant administrative burden it introduces.
- DRT participants emphasized that accurate and timely attribution is crucial for the success of any payment model, ensuring that practices are properly compensated and incentivized to provide high-quality care.

Lastly, Andy revisited the overall payment design component structure and stated that incentive payments will be a discussion topic for a future DRT meeting. He stated that incentive payments may be paid using a pay-for-performance methodology, which supports quality improvement in primary care for Health First Colorado members.

The SE team invited DRT participants to share their thoughts about a pay-for-performance methodology. Questions asked were:

- How does a pay-for-performance model resonate with you as to how HCPF rewards high-value care?
- Are there scenarios in which incentive payments are not always tied to quality (ex: advanced primary care)?

Questions and feedback from DRT participants are below.

- DRT participants believed that a pay-for-performance model resonates with pediatric primary care if there would be additional dollars provided to a practice on top of FFS and noted that annual payments would have no downside risk. A DRT participant stated that this additional money would be a value add to reflect actual practice performance versus just a budget neutral shift of money.
- DRT participants desired to have incentives to accept new patients and encourage open access.
- DRT participants pointed out that payment solely linked to clinical quality would have the following concerns:
    - Accounting for various practice experience levels that practices have with regards to primary care activities like integrated behavioral health that may impact outcomes.
    - Accurately assessing payments which are not linked to clinical quality since they would have to be linked to structural measures, which are difficult to track for practice performance. A DRT participant suggested following Current Procedural Terminology (CPT) codes for counseling and care coordination to measure integrated behavioral health.
- A DRT participant differentiated between pay-for-performance and the proposed prospective payment option, noting the limited evidence for pay-for-performance in reducing costs or improving quality but recognizing its potential as a positive starting point for practices.
- A DRT participant expressed concerns regarding the achievability of immunization benchmarks by a rural provider, questioning whether incentive measures would apply to individual measures or collectively, in light of challenges like vaccine hesitancy affecting the ability to meet specific benchmarks.
    - Staff responded that incentive payments would be a topic for discussion in following meetings but may look at the aggregate.

- Some DRT participants noted that a structural measure, like offering Vaccines For Children (VFC) at the point of care, could be a possible incentive metric for practices who serve vaccine-hesitant patients.

4. Looking Ahead

Suman Mathur provided a list of resources and reminded DRT participants about the next meeting on May 22nd from 5-7pm. Suman then closed the meeting.