PACK
Design Review Team

Meeting 6

May 8, 2024

Agenda

1. Welcome and Introductions
2. PACK Design Scope
3. Potential PACK Payment Methodology Options
4. Looking Ahead
5. Questions

Today's Objectives

1. Level-set on PACK design scope and working assumptions
2. Introduce considerations for PACK payments
3. Introduce examples of payment design elements
4. Gather feedback on payment mechanism pros and cons
5. Gather feedback on a pay-for-performance model

1. Welcome and Introductions

Meet the PACK Team

Devin Kepler
PACK Lead

Dr. Katie Price
Pediatric Consultant

Suman Mathur
Design Review Team Facilitator

Emily Leung
Design Review Team Co-Facilitator

Samantha Block
PACK Support Team

Andy Wilson
PACK Support Team

Puja Patel
PACK Support Team

Activity 1: Icebreaker

Mentimeter: Would you rather…?

Approval of Meeting Minutes

- Any proposed changes to minutes from Meeting 5?
- Any objections to posting a de-identified, abbreviated version of this document to the HCPF website (publicly accessible)?

PACK North Star

Every child and adolescent with Health First Colorado has the opportunity for a healthy childhood via equitable engagement with a primary care medical provider which is pediatric wellness-focused. This provides access to the prevention and management of illness, injury, and behavioral health services, which maximizes the physical, developmental, and behavioral outcomes of every child and adolescent member.

PACK Goals

Goal 1
Improve medical outcomes for child and adolescent members

Goal 2
Improve developmental and behavioral outcomes for child and adolescent members

Goal 3
Reduce disparities for key primary care outcomes across the state

Goal 4
Increase access to pediatric primary care for child and adolescent members

Goal 5
Improve member and family experience

Goal 6
Develop a pediatric value-based payment program that is sustainable for both providers and HCPF

Key Topics for the Design Review Team

✓ 1. **Goals and Objectives:** What are we trying to achieve?

2. **Quality Measurement and Quality Target Setting:** How will performance be measured for both informational and payment purposes?

3. **Payment:** What adjustments to payment are needed to adequately support high-value care delivery? What is the mechanism of how providers will be paid?

4. **Performance Improvement:** What information do you need to be successful?

5. **Program Sustainability:** What types of support will be needed to sustain this program?

2. PACK Design Scope

Aligning on PACK Scope to Level-Set on Payment

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.

	Members:	Participating Providers:	Services:
In Scope	All pediatric-aged Health First Colorado members	All PCMPs with attributed pediatric-aged members	All primary care services that include CPT codes defined under the APM 2 program
Out of Scope	**Total out of scope** • Denver Health Medicaid Choice • Rocky Mountain Health PRIME • Child Health Plan Plus (CHP+) • Incarcerated Benefited Plan • Emergency Medicaid • Family Planning	• Non-PCMPs who provide services to pediatric-aged members • PCMPs who do not have attributed pediatric-aged members	• **Any procedures outside of APM 2 CPT codes**

The focus of PACK is on preventative primary care services and includes all child and adolescent members, including medically, socially, and behaviorally complex child and adolescent members.

Level-Setting on PACK Payment Design

- As the PACK program develops, PACK payment design may evolve (i.e., alignment with other initiatives such as ACC Phase III and Integrated Behavioral Health).
- Implementation of incentive payments are dependent on State Plan Amendment (SPA) approval and budgeting.

PACK Payment Models Should Be Appropriate for Pediatric Primary Care

From discussions with stakeholders, we have heard that **shared savings, Total Cost of Care (TCOC), or downside risk models** are not appropriate for pediatric primary care. We are considering not using either of these model options for the initial phase of PACK.

In the next few slides, we will discuss each of these models and discuss whether these models are appropriate for pediatric primary care.

Defining Shared Savings and TCOC Models

- Agreement is made on financial and quality benchmarks specific to primary care services between providers and the Department.
- Shared savings and TCOC are in place if primary care services are provided below the financial benchmark, while maintaining or improving performance on quality measures.
- A shared savings and TCOC would emphasize cost-efficiency.
- It creates potential for increased revenue for providers through effective cost management and service delivery.

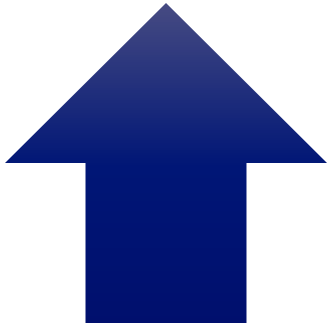
What We've Heard: Shared Savings and TCOC Models

- **Demand for Preventative Pediatric Care:** During discussion with stakeholders, many questioned the potential for cost savings in pediatric primary care due to the need to increase preventative pediatric primary care services.
- **Upfront Investments:** Pediatric care requires proactive measures like vaccinations and screenings, which yield long-term savings.
- **Focus on Preventative Care:** Preliminary data shows the frequency of services for treating common chronic diseases in the pediatric population, such as obesity, asthma, and diabetes, is low compared to primary care-related services.

Mentimeter and Discussion: Shared Savings and TCOC Models

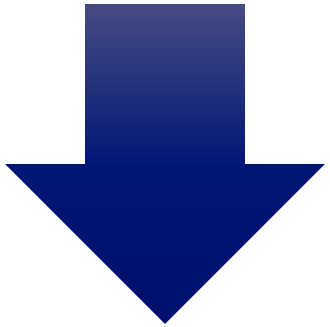
- Using Menti, on a scale of 1-5 (1 being strongly disagree, 5 being strongly agree):
  - Do you agree/disagree that **shared savings and TCOC** make sense as a payment mechanism for pediatric primary care?
  - Do you agree/disagree that **shared savings and TCOC** supports the PACK goals?
- Do you have additional considerations for the inclusion or exclusion of **shared savings or TCOC** in PACK?

Defining Upside vs. Downside Risk Models



Upside Risk:

- Opportunity for providers to gain additional revenue if quality measures are maintained and/or improved.
- If quality measures are not met, providers simply do not gain additional revenue.
- Encourages high quality care without getting penalized.



Downside Risk:

- Providers bear the risk of financial loss if quality measures are not met.
- Encourages careful resource management and steadfast commitment to quality care.

What We've Heard: Downside Risk Models

- **Potential Compromise in Access:** Downside risk model may discourage pediatric practices from accepting Medicaid patients to avoid potential losses.

Mentimeter and Discussion: Downside Risk Models

- Using Menti, 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?
  - Do you agree/disagree that **downside risk** supports the PACK goals?
- Are there scenarios where **downside risk** would make sense?
- Do you have additional considerations for the inclusion or exclusion of **downside risk** in PACK?

3. Potential PACK Payment Methodology

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*.

Discussion: Considerations

- What considerations resonate the most?
- Are we missing any?
- Should any be changed?

Overall Payment Design Components

Primary Care Services

Payment for APM 2 code set:

- E&M – Preventative/Well-Child Check
- E&M - Office/Other Outpatient
- Immunization Administration
- SBIRT
- Depression Screening
- Blood Draws
- OB/GYN Preventative – Pap smear, vaginal, pelvic, and breast exams/screenings

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Incentive Payments

Payment contingent on meeting standards for 6 DOI Pediatric Measures:

1. Well-Child Visits in the First 30 Months of Life Measure (W30)
2. Child and Adolescent Well-Care Visits: Ages 3 to 21 (WCV)
3. Childhood Immunization Status (CIS)
4. Immunizations for Adolescents (IMA)
5. Developmental Screening in the First Three Years of Life (DEV)
6. Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF)

How to Pay for Pediatric Primary Care Services

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Primary Care Service Payments

Fee-For-Service (FFS)

- Providers are paid for each individual service rendered
- Payments are based on type, quantity, 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

Example Scenario 1: FFS

*Practice X (1,500 members) performs 2,100 established preventative visits (600 for infants, 400 for ages 1-4, 500 for ages 5-11, and 600 for ages 12-17), **1,500** office visits, 550 depression screenings of which 200 were positive and require follow up.*

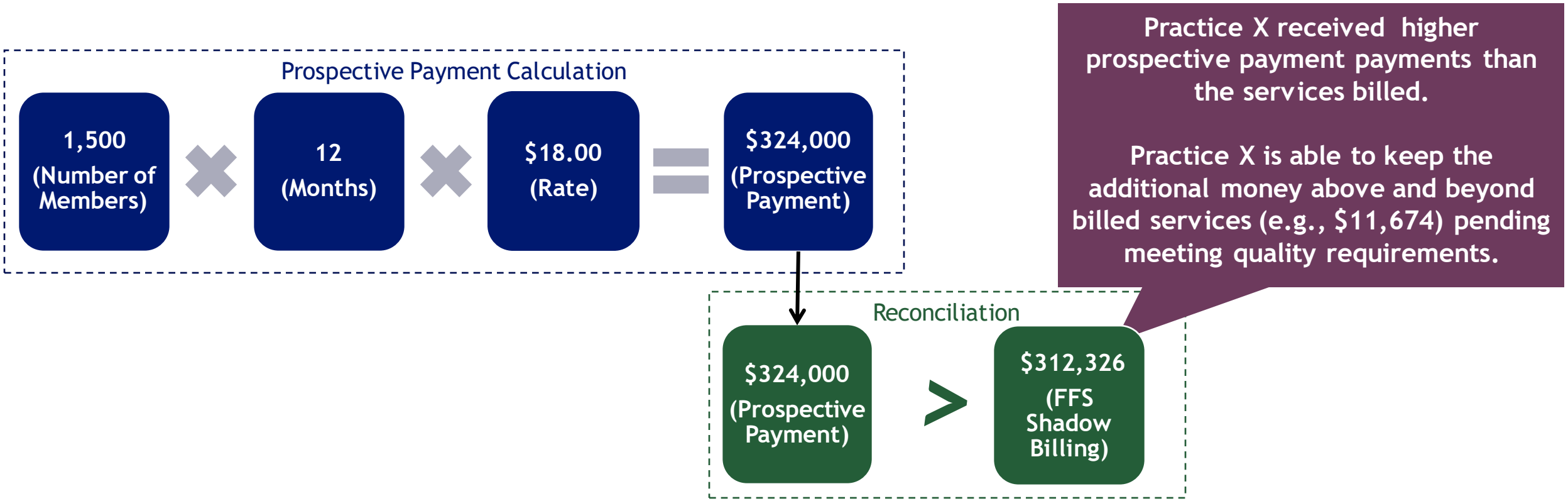
CPT Code	Visits	Jan 2024 HCPF Fee Schedule	Total Payment
99391: Periodic preventive medicine reevaluation and management, Established Patient, Infant	600	$84.37	$50,622
99392: Periodic preventive medicine reevaluation and management, Established Patient, Ages 1-4	400	90.16	$36,064
99393: Periodic preventive medicine reevaluation and management, Established Patient, Ages 5-11	500	$89.86	$44,930
99394: Periodic preventive medicine reevaluation and management, Established Patient, Ages 12-17	600	$98.45	$59,070
99213: Established patient office visit, 20-29 mins	1,500	$74.02	$111,030
G8431: Depression Screening Positive; Follow Up Required	200	$32.54	$6,508
G8510: Depression Screening Negative; No Follow Up Required	350	$11.72	$4,102
Total Payments Received			**$312,326**

Practice X received FFS payment of 312,326.

Example Scenario 1: Prospective Payment

Participating practices may select between 0 - 100% of their revenue to be received as a partial prospective payment reflecting attributed members each month.

Practice X (1,500 members) decides to take 100% prospective payment at $18 Per-Member-Per-Month



Example Scenario 2: FFS

*Practice X (1,500 members) performs 2,100 established preventative visits (600 for infants, 400 for ages 1-4, 500 for ages 5-11, and 600 for ages 12-17), **1,800** office visits, 550 depression screenings of which 200 were positive and require follow up.*

CPT Code	Visits	Jan 2024 HCPF Fee Schedule	Total Payment
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99394: Periodic preventive medicine reevaluation and management, Established Patient, Ages 12-17	600	$98.45	$59,070
99213: Established patient office visit, 20-29 mins	1,800	$74.02	$133,236
G8431: Depression Screening Positive; Follow Up Required	200	$32.54	$6,508
G8510: Depression Screening Negative; No Follow Up Required	350	$11.72	$4,102
Total Payments Received			**$334,532**

Practice X received FFS payment of 334,532

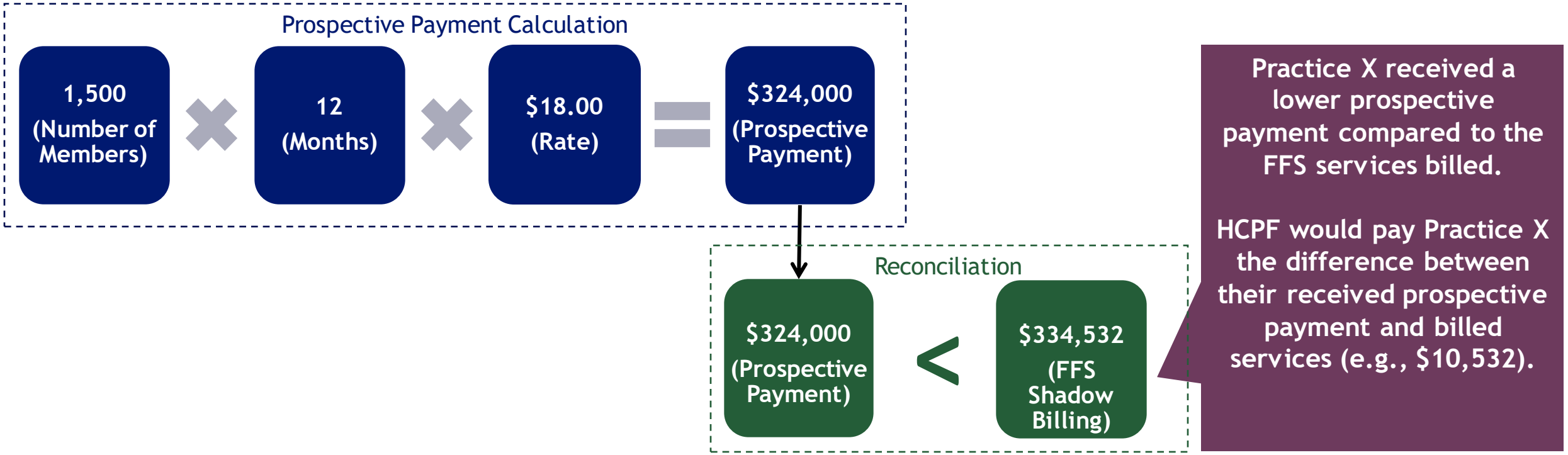
Discussion: Prospective Payment for Pediatric Primary Care Services

- 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?

Example Scenario 2: Prospective Payment

Participating practices may select between 0 - 100% of their revenue to be received as a partial prospective payment reflecting attributed members each month.

Practice X (1,500 members) decides to take 100% prospective payment at a $18 Per-Member-Per-Month



How to pay for incentive payments: Pay-for-Performance

We will focus on this during future sessions.

Primary Care Services

Payment for APM 2 code set:

- *E&M – Preventative/ Well-Child Check*
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- *Immunization Administration*
- *SBIRT*
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Incentive Payments

Payment contingent on meeting standards for 6 DOI Pediatric Measures:

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5. Developmental Screening in the First Three Years of Life (DEV)
6. Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF)

Defining Pay-for-Performance

- Offers financial incentives to practices based on their quality measure performance.
- Supports quality improvement in primary care for Health First Colorado members.

Discussion: Pay-for-Performance

- 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)?

More discussion on exact payment mechanism(s) to come in future meetings.

4. Looking Ahead

What's Next

- **Next DRT Session:** Wednesday, May 22, from 5 to 7 pm
- **Questions?** Please email us at HCPF_VBPStakeholderEngagement@state.co.us

Upcoming DRT Meeting Topics

Date	DRT Session	APM Framework Component	PACK DRT Session Topic (Subcomponent)
Feb 6	1	DRT Overview	Sessions, expectations, background
Feb 28	2	Goals and Objectives	Feedback on goals
Mar 13	3	Quality Measurement and Quality Target Setting	Feedback on quality measures and targets as well as operationalization
Mar 27	4	Payment	Feedback and proposed considerations for attribution method
Apr 24	5	Quality Measurement and Quality Target Setting	Feedback on quality target setting methodology
May 8 – Today!	6	Payment	Overall process of payment for services
May 22	7	Payment	Overall process of payment for quality
June 12	8	Payment	Overall process of risk adjustment and reconciliation
June 26	9	Performance Improvement	Actionable insights, provide must-haves, nice-to-haves
July 10	10	Program Sustainability	Prioritize types of support

Questions?