Performance Measurement and Member Engagement
PIAC Subcommittee
Minutes

Meeting Information			
Date	Thursday, May 28, 2020	**Time**	3:00 – 4:30 PM
Location	Virtual attendance only	**Call-in Number**	+1 402-364-0128 PIN: 205 793 916#
		Webinar link	meet.google.com/ohd-ofqc-scd
Committee Purpose	Discuss best practices and challenges to improving quality and health outcomes for ACC members and make recommendations for the ACC PIAC and the Department with regard to quality.		
Meeting Purpose	Learn the basic structure of the Alternative Payment Model (APM) and become familiar with the performance measures. Provide feedback to the Department to impact January 2021 APM measure selection and COVID adjustments.		

Voting Members and Participants
Voting Members Present: Jill Atkinson (Community Reach Center), Deb Barnett (Connecting Points Advisory), Eli Boone (Colorado Health Institute), Bob Conkey (Health First Colorado member), Jerry Evans (Community Health Initiatives), Angie Goodger (CDPHE), Valerie Nielsen (CCHN), Brandon Ward (Jefferson Center for Mental Health), Luke Wheeland (The Arc), Kayla Frawley (Clayton Early Learning) **Voting Members Absent:** Gary Montrose (Healthcare Strategies) **Co-Chairs:** Bethany Pray (CCLP), David Keller (Children's Hospital) **HCPF Staff:** Megan Comer, Ben Harris, Seth Lewis, Amy Luu, Liana Major, Nicole Nyberg, Jed Ziegenhagen, Nicole Nyberg **Other Participants:** Tammy Arnold (NHP), Erica Arnold-Miller (Health Colorado), Lynne Bakalyan (Beacon), Byron Burton, Marjorie Champenoy (RMHP), Dawn Claycomb (Beacon), Julia Duffer (HCI), Jeani Fricky Saito (SCL Health), Katie Gaffney (Denver Health Medical Plan), Jen Hale-Coulson (Beacon), Kate Hayes (Planned Parenthood), Camila Joao (CCHA), Nicole Konkoly (RMHP), Sarah Lambie, Carlos Mardrid (Kaiser Permanente), Alma Mejorado (Beacon), Anna Messinger (RMHP), Catherine Morrisey, Katie Mortenson (CCHA), Jane Reed (Colorado Access), Kellen Roth (CO Access), Annie Schudy (RMHP)

Speaker(s)	Description
DK, BP	Roll call and April minutes approved. No abstention.
LM/MC	**Update on COVID measure and member recruitment** COVID-19 measure • Further information regarding what the RAEs are doing in terms of COVID can be shared with this group. • There were questions of how this group's feedback was incorporated as thoughts were shared that the biggest point was to be sure that guidance was bi-directional engagement. ○ In response, the key target is the phone calls between the RAEs and members directly. It's easier for RAEs to collect this data as opposed to collecting data of communication between providers and members. One

	directional outreach goal is to outreach to 100% of members. Health First Colorado Member Recruitment • In the previous meeting, PMME voted to approve up to four new Medicaid members. • HCPF (the Department) looked into potentially including CHP+ members; however, it was determined that these members would not be an ideal fit and would get much value in participating due to the lack of alignment between the Accountable Care Collaborative (ACC) and the CHP program. As the ACC and CHP move toward greater alignment in the next 12 months, this decision can be reconsidered. • Sarah Eaton at the Department is recruiting through the state Member Experience Advisory Council (MEAC) and the virtual MEAC, which is a list of about 1,200 people. Kayla is also helping to recruit through Clayton Early Learning. • A suggestion was made for current voting members to invite friends and colleagues to join these meetings as that has seemed to be the best way to engage others. • Next steps will be to present the list of interested individuals to this subcommittee for selection. • A current Health First Colorado member and voting member, Bob, discussed member recruitment with other Health First Colorado members. He mentioned that compiling a list of commonly used acronyms and terminology would be helpful for retention. Thoughts were shared that materials like the list would help with retain Health First Colorado members. There is a need to acknowledge this to the new members, that they may not have much knowledge about the information presented as some can be very high-level. • There is a need to onboard voting members better and to be inclusive so it's a positive experience for new members. The Department and several current voting members are working to address this and we welcome ideas and participation.
NN/JZ/SL	**Alternative Payment Model (APM) Basics** More detail is available on slides posted to the PMME website: https://bit.ly/3h0xzyv • The APM is a quality-based payment model in which primary care medical providers (PCMPs) are rewarded for the quality of care they provide to Health First Colorado members. It is meant to reward performance and introduce accountability for outcomes and access to care. • There are three objectives of APM: (1) Provide long-term, sustainable investments to primary care; (2) Reward performance and introduce accountability for outcomes and access to care while granting flexibility of choice to PCMPs; and (3) Align with other payment reforms across the delivery system. • The Department has been trying to align the APM with other payment reforms across the delivery system to ease the administrative burden among practices. • 2020 APM measure alignment ○ APM measures were developed through a stakeholder process that occurred in the previous year. The goal was to ensure APM measure domains were similar across providers. APM measures have been aligned with other state and federal program measures. For instance, the following focus areas like, maternity, chronic care management, dental care, substance use, mental health, wellness, hospital utilization, and specialty care, align relatively well with other programs the Department is currently focused on. These programs

include the Hospital Transformation Program, ACC Key Performance Indicators (KPI), ACC Behavioral Health Incentive Program and Quality Payment Program.

- History of the APM.
  - The APM was created from the FY17-18 budget request to implement increased rates tied to value-based payment. The effort was implemented in the fall of 2018.
- Eligible practices
  - To be eligible for the APM, PCMPs need to have either 200 lives attributed within the ACC or have more than $30,000 in historical annual paid claims. PCMPs that do not meet these criteria are automatically excluded and will not experience an increase or decrease in their rates. PCMPs that are eligible to participate in the APM but choose not to do so will see a decrease in their rates.
- There was a question regarding what percentage of practices in Colorado meet these eligibility criteria?
  - Jed estimated that about higher than 90% of practices meet one of the eligibility criteria, which includes CPC+ practices and FQHCs. So, if someone were to select a Health First Colorado member at random, it would be very likely that a member's PCMP is impacted by the APM.
- The Department noted that measures across programs (e.g., APM, HTP, KPI) have to be different by nature. The well visit code set in the APM is also in the KPI; however, it is broader than the KPI measure. The alignment is not on the measure itself but is on the focus area (or domain) and ensuring that all programs are supporting one another as opposed to conflicting. Although it may be true that practices don't appreciate this alignment across domains when they still have to calculate measures differently.
- APM: how it works
  - Practices select 10 measures they want to base their performance on. At the end of the performance year, each practice submits a set of Electronic Clinical Quality Measure (eCQM), structural measure data, and claims measures. Each practice receives an APM Quality Score based on performance in their selected measures showing how they did. A workbook is available on the Department's website which shows how points are assigned to each measure and how practices are scored. In particular, the amount of possible points a practice can earn are assigned to each measure. A practice will earn a portion or all of these points. As long as a practice earns at least 200 points, their payment will not be reduced. If a practice earns less than 200 points, their payment will be reduced.
- APM 1 Measure types.
  - There are practices in advanced quality programs that may not need as much support, but there are also practices that have never participated in a quality program. Structural measures focus on a practice's capacity, systems and processes to provide high-quality care. eCQM and claims measures are weighted a little bit higher as there are clinical outcomes and clinical results that the Department wants to see movement in. The way in which the Department measures and rewards points targets a 90th percentile and that is the goal, but practices must gradually "close the gap" to work towards that goal over time. As long as they meet incremental progress targets, then they can earn points (slide 13, 3% is the percentage improvement required). Due to limited data available for the state of Colorado, goal measures have been

	set higher. ○ A question was proposed if the goal was based on CPC+, which would mean pediatric measures are not included in this. In response, Colorado State Innovation Model (SIM) data was used. The Department can share the way each goal was calculated. • The APM is budget neutral. Money is redistributed to practices based on how many hit their goals or don't. The more that hit their goals, the less there is to pay out. COVID-19 related budget cuts are not anticipated to impact the rate structure because APM is budget neutral. • A situational question was asked regarding one health center not earning 200 points and if only this specific site's fee schedule is reduced or if the entire organization will be impacted. The question was whether or not this would radiate out to the entire organization. In response, the Department can differentiate across sites within a single entity. • COVID impacts on two cohorts for the APM. ○ For cohort calendar year 2019, the eCQM measure collection and structural measure attestation has been paused. This means different things for RAEs and PCMPS. PCMPs are invited to report and complete any work they would like. The RAEs were told not to engage in collection. However, if RAEs wanted to engage, then they may. ○ For cohort year calendar 2020, the impact is still to be seen. PCMPs were asked if they were able to participate in a clinical trial and they have the ability to gain points from this. The Department is looking at a few different solutions for small practices affected by COVID, who are unable to participate in clinical trials, to still be able to gain points. A discussion has occurred with the RAEs to discuss the impact on their contracted PCMPs and giving credit for the PCMPs' response to COVID.
DK/BP	**Discussion and feedback on APM topics** There were four questions up for discussions: (1) If APM measures are too easy to hit, all practices earn money which can disincentivize high performers. If they are harder, some practices may earn less money. Which way should APM lean? (2) Of the ~ 60 measures, which are most important, to members and to capturing all that primary care should offer? (3) Are there types of measures you don't see on this list that would be valuable to ensuring positive health outcomes for members? (4) Are there opinions about the addition of one or more COVID measures to APM this year? These could offset low performance if targets are not met. To maximize limited time and focus where there was the greatest opportunity for immediate impact, the group agreed to focus on the fourth question. The Department shared that they are considering giving primary care practices credit if they were to choose and meet one of the following three COVID measures. These are still high-level and need further definition. (1) Participation in clinical COVID trials (2) Outreach and engagement to high risk members (COVID response – similar to the COVID plan discussed in April)

	(3) New use of telehealth <u>Participation in clinical COVID trials</u> • David shared that this COVID measure would not be relevant for pediatricians because they generally can't participate. Clinical trials are rare because case rates for child are low. Practices aren't expected to start clinical trials either. David thinks it's fine to keep this as an option for a COVID measure, as long as it's not the only option. • We could measure follow up care to children and their mothers, but it's unclear what exactly the measure would be. <u>Outreach and Engagement</u> • This measure was not discussed by the group <u>New use of telehealth</u> • Deb asked how the Department is considering measuring telehealth. It's important to recognize that anything related to COVID will be a fast-moving target as things have continuously evolve. There is a need to take into consideration that whatever is being defined now may no longer be relevant in November. A suggestion was made to measure transition; for instance, if a service is provided during a defined amount of time, then it will not be impacted by the continually evolving conditions. • As practices started doing more telehealth, they had to shift their focus which impacted work on the other 60 measures. Numerators for vitals such as BMI are dropping due to video appointments. Families don't necessarily have access to the telehealth tools that we need to take vitals. • Brandon suggests that instead of incentivizing the pure use of telehealth, we should incentivize the right level of data sharing or information so we can study how efforts are ultimately impacting delivery. • Valerie suggested that we consider audio telehealth as well as video. Both are useful, particularly for FQHCs. • If telemedicine becomes a structural measure and practices have already selected the maximum number of allowable structural measures, can they still choose a structural COVID measure? The Department did not directly respond to this. • Bethany asked, "What kind of telehealth use is most valued by members, and what telehealth does the Department want to incentivize, such as the prevention of ER use." Have there been efforts to gather information of what aspects of telehealth have been helpful to members. And has the Department's Member Experience Advisory Council been interested in discussing this topic? • Luke mentioned that for the Arc Arapahoe & Douglas Counties, tele-behavioral health has helped patients who have difficulty being in a room for a long amount of time. Using telehealth to do routine check-ups by CNAs has also been helpful. • Jill says that telehealth has helped reduce no show rates. It also has opened a new, useful strategy for patients struggling with transportation. It's also been a useful tool for following up on medication. On the pediatric practice side, families have appreciated telehealth due to the fear of leaving their homes. Some providers have not been thrilled about telehealth video, as it's difficult to use tactile senses that may be heavily relied on for appointments.

	• Brandon said that at the Jefferson Center for Mental Health, 82% of their patients reported preferring telehealth appointments moving forward, with preference split between phone and video. • Bob said the state MEAC has talked about this topic. Members in rural areas really liked it because it shortened their commute to providers. But people who didn't like it were those with technology limitations or who had government issued phones. For the patients where telehealth does not work for them, there is concern they will be lost in the shuffle. Some members have a hesitancy to use telehealth. • The question was asked, "What types of telemedicine data are being tracked by the Department and at what level of detail? Is the Department differentiating visits between new versus existing patients, for instance?" HCPF can track telemedicine visits for physical versus behavioral health but cannot tell by claims data whether it's a phone or video visit. • It was suggested to incentivize the provider community to study telehealth use on a larger scale, if possible. Although, there was uncertainty as to how this could be operationalized. • A comment was shared: Are the way practices are trying to combat the loss of well visits being looked at and what is being done to revive immunization rates? David mentioned that one option may be to look at the immunization rates for babies as a separate measure because no one is doing that yet. But otherwise, there was no answer to this question. • Someone also asked, of the approximately APM measures, which were most frequently selected by practices. The Department said that structural measures are most common, followed by eCQMs then claims. For structural measures, "Accepting New Patients" and "Team Meetings" are the most common. For eCQMs, "High Blood Pressure" and "Tobacco Cessation" are the most common." • PMME's feedback on the APM COVID measure does not need to be solidified until late summer. Feedback will go to the APM stakeholder group next. There is time for further discussion.
DK/BP/Dept	**Next steps on APM and wrap-up** • Compile feedback from PMME members between now and the next meeting or revisit this discussion at the June meeting (to be determined). • Share by email new member recruitment materials so PMME members can help spread the word. • Next meeting: ○ Thursday, June 25 from 3 – 4:30 PM

Meeting Action Items					
Date Added	**Action No.**	**Owner**	**Description**	**Due Date**	**Date Closed**
5/28/2020	1	Dept	Share member recruitment information with PMME members	6/12	
5/28/2020	2	PMME	Gather additional feedback on the telemedicine COVID measures for APM	TBD	