MINUTES
Primary Care Alternative Payment Methodology (APM)
Track 2 Workgroup

303 East 17th Avenue, 11th Floor Conference Room 11A

February 14th, 2017
3:00 to 4:30 P.M.

1. Welcome and Introductions

Shane Mofford, Payment Reform Section Manager called the meeting to order at 3:05 P.M.

This workgroup will work through the operational detail needed to implement primary care capitation models like those proposed by Medicare in the CPC+ initiative under the Track 2 Payment. The feedback and discussion from this workgroup will help guide the Department in creating Track 2 payment model designs for Colorado PCMPs. This will not be the only workgroup for Track 2 payment models.

Review of primary care APM guiding principles. These have been updated and streamlined since our first meeting, if you would like any other changes please let us know.

Guiding Principles

Any payment criteria created should adhere to the following principles:

- Align with the Health First Colorado delivery system and with broader delivery system and payment reform efforts.
- Create flexibility in primary care payment models to allow for changes in business practices and to achieve increased efficiencies.
- Be tied to clinically meaningful performance criteria designed to improve outcomes and achieve population health goals
- Have a data feedback loop for providers to receive actionable recommendations
- Have a realistic timeline for practice transformation with input from stakeholders
- Ensure regional and practice differences are addressed and that reforms work for all of Colorado
Measurement Principles:

- Measures good clinical practice rather than driving process change towards a measure
- Measures are currently reportable
- Measures should be statistically valid
- The numerator and denominator of the measure are broadly applicable to account for practice/panel variation
- Measures should be able to provide the Department and providers with real-time monitoring of performance

The Department is holding primary care stakeholder workgroups broken into six groups with different expertise emphasis (criteria, measurement, designation, payment design, attribution, Track II) the workgroups all overlap so please consider how the review and discussion of the alternative payment criteria may influence other meeting groups.

2. Quick review of lessons learned to date

Here are the lessons that the Department has taken from the first series of meetings:

- Practices feel they can achieve desired outcomes without the highly prescriptive structural criteria in place and flexibility is important
- Rural vs. Urban is not a sufficient delineator – practice size matters, as does a consideration for the population served (pediatric for example)
- Many structural criteria are already common place and having metrics attached to payment may not be as meaningful
- These factors lead us to the conclusion that we need to incorporate performance criteria rather than focusing solely on structural criteria
- Alignment with other state and federal initiatives is key to success and avoiding reform burnout
- Flexibility in choice of measures and keeping administrative burden low are two of the most important things for practices

3. Overview of Medicare’s Track 2 payment model

CPC+ was developed by the Center for Medicare and Medicaid Innovation. CPC+ is a regionally-based, multi-payer care delivery and payment model that includes two separate tracks. The program requirements ensure that practices in each track will be able to build capabilities and care processes to deliver better care, which will result in a healthier patient population. Practices in both tracks will be expected to make changes in the way they deliver care, centered on key Comprehensive Primary
Care Functions: (1) Access and Continuity; (2) Care Management; (3) Comprehensiveness and Coordination; (4) Patient and Caregiver Engagement; (5) Planned Care and Population Health.

Track 1 practices will continue to receive Medicare fee-for-service payments. In Track 2 of CPC+, CMS is introducing a hybrid of Medicare fee-for-service payments and the “Comprehensive Primary Care Payment” (CPCP). The CPCP changes the cash flow mechanism for Track 2 practices, promotes flexibility in how practices deliver care that is traditionally provided face-to-face, and requires practices to increase the depth and breadth of primary care they deliver. For attributed Medicare beneficiaries, Track 2 practices will receive a percentage of their expected Medicare reimbursement for Evaluation & Management (E&M) claims payment upfront in the form of a CPCP and reduced Medicare reimbursement amounts for E&M claims Track 2 practices must demonstrate Track 1 clinical capabilities and commitment to enhanced health IT when they apply, and commit to increasing the depth, breadth, and scope of care offered, with focus on patients with complex needs.

4. Colorado’s Track 2, questions and considerations of proposed models

Discussion questions and considerations:

- Who is eligible to participate?
- Practice characteristic considerations:
  - Experience managing a panel
  - Size of panel
  - Medicaid revenue
  - Other?
- Model structure:
  - Current percent capitation vs. percent FFS, should there be choice on this?
  - Same codes as Track I?
- Accountability mechanisms
  - Utilization rates
  - Quality targets
  - Required reporting
- Payment reconciliation
- Attribution
- Quality incentives

There are a couple of things practices need to do to transition from a volume based business model: accept risk and have active panel management. Should there be a critical mass requirement for panel size for this model to make sense for a business?
Colorado has participated in CPC+ and CPCi models and multi payer initiatives. The Department wants to align with other payment reform initiatives to avoid reform fatigue and wants to build the Track 2 model with stakeholders.

The Department has been working with stakeholders and incorporating their feedback into the Track 1 model (primary care alternative payment methodology workgroups). Track 2 will build off this work to include:

- Hybrid model for capitation and FFS payments
  - Practices will get both a cap and FFS

Practices will have the same amount of money available to earn but, will have a guaranteed revenue stream (capitation) and opportunity for FFS payments. This will allow for practices to work on and improve structural (practice characteristics) criteria. We will start with the Medicare model of Track 2 and ensure alignment with CPC+. This would affect a limited set of codes which would be the same as Track 1.

Discussion and feedback:

Retrospective claims data to see what the initial rate would be?
  - Yes, like managed care rates, probably some risk adjustment

Risk stratification for panel size?
  - Yes. If you didn’t risk stratify you would incentivize cherry picking of patients

Patient social determinants of health (SDH) risk stratification?
  - Access to that data issues
  - Makes sense from a payer’s perspective
  - Clinic evaluation of SDH to adjust risk?
    - Philosophical sense not operational sense- too hard to do for every client
  - Stop/loss for complex clients

Not limited to any subset of clients (Medicaid)
Clinics can’t spend time on which client is on what payment model, needs to impact our entire panel for better clinical outcomes

First year or two clinics tend to underestimate the risk score of the patients
See a drop-in revenue the first year while we are ramping up and reimbursements don’t catch up or help

Initial cut of this model would be inclusive of entire panel (attributed clients)
Can anyone see any risk for including entire panel? No
This money is intended for X: why are you using Medicaid dollars on non-Medicaid clients? The Feds don’t care about how providers use the money just how the Department (aside from managed care rates) uses it.

How practices use their dollars is not the Department’s concern: we care about the outcomes (performance and structural)

How does rate setting come full circle? 
Still have FFS billing: still collecting claims and always have record of utilization

Attribution concerns/needs
- New patients coming in- how do you get paid for them?
- Using clients historical average
- Attribution is functionally needed
- Tie FFS to attributed members as well

How to rebase the rates- keep getting utilization?
- Indexing process (would violate budget authority)
- CPI concept
- Apply to rates periodically to keep them current

Ratchet down effect?
Need to demonstrate value in delivery system before we can start doing this

Where does the upfront investment come from?
- One- year time horizon is too short
- Support R6 in the Department’s budget request
This starts in the upstream (primary care) to avoid more expensive downstream effects (hospitals)

Risk score lag issue
- Get initial score: clinics aren’t generally used to getting it, need a longer ramp time
- Lower risk to attributed population happens first, then payer beefs up accountability and provider has less resources to work with if doing poorly

Claims and costs vs. HCT codes
- Need to do a better job describing/coding to be able to reflect patient’s risk
- Providers will undervalue patient risk

Different methodology to load patient data in a full way
- Give providers opportunity to do in depth codes for patients
Risk scoring is based on?
- All codes not just PCMP
- Looking at your utilization for your panel (may not risk adjust for LTSS panel composition)
- See if you are getting a similar amount of revenue as you have in the past
- Hybrid model, FFS and Capitation
- Ramp up over time makes sense and will help providers

What portion should be under capitation and under FFS?
- Practice size/capabilities matters (look at CPC+ map for where practices are in CO are)
- Expected level of participation: about 20 practices across the whole state
- Will be more advanced practices
- What practice supports/entry criteria for practices to participate?

Does panel size matter? CMS set attribution threshold of 150 beneficiaries
- Of all your aligned payers, what percentage of panel is in this track?
- More payers aligned the more they will succeed
- Percentage not number in panel for smaller practices
- Graduate from Track I into II
- Experience of practices in different payment models (like payment design model)

Model structure
- Building something that makes sense for Colorado

What types of options would we have available for percent capitation vs. percent FFS payments?
- Go straight to capitation? Risk that patients don’t get what they need

Hitting quality measures (or not) where does the reward punishment happen?
- Quality vs. cost measures
- Total cost relativity from Rocky PRIME, acknowledge that PCMPs have impact on total cost but not complete control
- Need to keep similarities of accountability for Track 1 and 2
- Use Medicaid revenue for determining caps and FFS rates?
- Have practices participate in decision making process on cap and FFS percentages

CPCi practices have a lot of these experiments but now it’s testing with CPC+
- Need to give practices an out if they can’t handle it

Urgent care and after hours (want extended hours and diversion from ER use)
- How to treat urgent care facility that is affiliated with a PCMP?
Attribution issues (reconciliations?)
  What are you doing within your practice? To improve internally? How to make practices demonstrate this?
  Attribution as the incentive for practices
  Client loyalty
  Lock-in

Patient choice and designation
  Re-designation to occur on a routine time?
  Community needs

Volume is still king, even for new MDs, this change will take a while to catch on

Accountability mechanisms:
  Utilization rates: when setting your encounter rates there is an assumption you are not earning the funding you aren’t reporting
  Quality- yes
  Reporting- what?
  Reconciliation processes
  Patient Feedback?

5. Adjourn

  • The Department has created an external website and dedicated email for Primary Care Alternative Payment Methodologies: primarycare.workgroup@hcpf.state.co.us