# Primary Care Payment Reform Collaborative Meeting

December 12, 2024

# Agenda

- Housekeeping & announcements
- Primary Care & APM Spending Report
- Update on Standing Committee on Primary Care
- Annual report recommendations
- Public comment

# Meeting Goals & Requested Feedback

## GOALS

- Review PC/AMP spending findings
- Learn about activities of Standing Committee on Primary Care
- Workshop annual report recommendations

## FEEDBACK

- Q&A with CIVHC about PC/APM data
- Identify intersections with work of Standing Committee and PCPRC
- Edits to recommendations report draft

* * Incorporate equity into discussion and recommendations * *

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# Housekeeping & Announcements

# Housekeeping & Announcements

- Meeting minutes – posting abbreviated minutes for Nov, Dec and Jan
- Welcome new member

**Kevin McFatridge**
Executive Director
Colorado Association of Health Plans

# Housekeeping & Announcements

- 2025 Meeting Schedule finalized

| | |
|---|---|
| Jan 9, 2025 | ~~Jul 10, 2025~~ |
| Feb 6, 2025 | Aug 14, 2025 |
| Mar 13, 2025 | Sep 11, 2025 |
| Apr 10, 2025 | Oct 9, 2025 |
| May 8, 2025 | Nov 13, 2025 |
| Jun 12, 2025 | Dec 11, 2025 |

Summer Holiday

Nov 14, 2024 10:00 AM Mountain Time (US and Canada)

Dec 12, 2024 10:00 AM Mountain Time (US and Canada)

Meeting ID 856 1865 0554

Passcode 917772

Add to Calendar(.ics) | Add to Google Calendar | Add to Yahoo Calendar

Register: https://us06web.zoom.us/meeting/register/tZMkdequrT4vHtX-7DQb0V8UY2Y7pW1ljRL4

# Federal Updates

- CMMI – Seventh Report to Congress
  - Strategic accomplishments
  - Updates on 37 models and initiatives
  - Activities from 10/1/22 – 9/30/24
  - Available here
- Open enrollment
  - Nearly 988,000 new consumers enrolled as of 12/5/24
  - Open enrollment runs through January 15

# 2024 Primary Care Spending Report

December 12, 2024

CIVHC

CENTER FOR IMPROVING VALUE IN HEALTH CARE

# Background

- Primary Care Spending Report satisfies statute:
  - CRS 25.5-1-204(3)(c)(II) - Report includes the percentage of medical expenses allocated to primary care, the share of payments that are made through nationally recognized alternative payment models, and the share of payments that are not paid on a fee-for-service or per-claim basis.


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# Report Content

- Analysis of primary care and Alternative Payment Model (APM) spending as a percentage of total medical spending for:
  - 2021, 2022, and 2023
  - Commercial, Medicaid, CHP+, and Medicare Advantage (excludes Medicare FFS)
- Does not include pharmacy or dental spending
- Two separate sources of information for report:
  - Carrier-submitted APM files (13 payers submitted APM files)
  - Claims from the CO APCD

# Report Content

- The same primary care and APM categorization methodology used in the 2023 report was applied here.
- Followed data collection and validation process established in 2021:
  - Qualitative field collection to ensure accurate APM categorization
  - Ensured carriers appropriately categorized FFS payments under larger APMs (i.e. pay for performance)
  - Attestation by C-suite payer representative
- Inclusion of payer vs. member portion of spend, prospective payment spending, and reporting of PMPM spending


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# Report Content

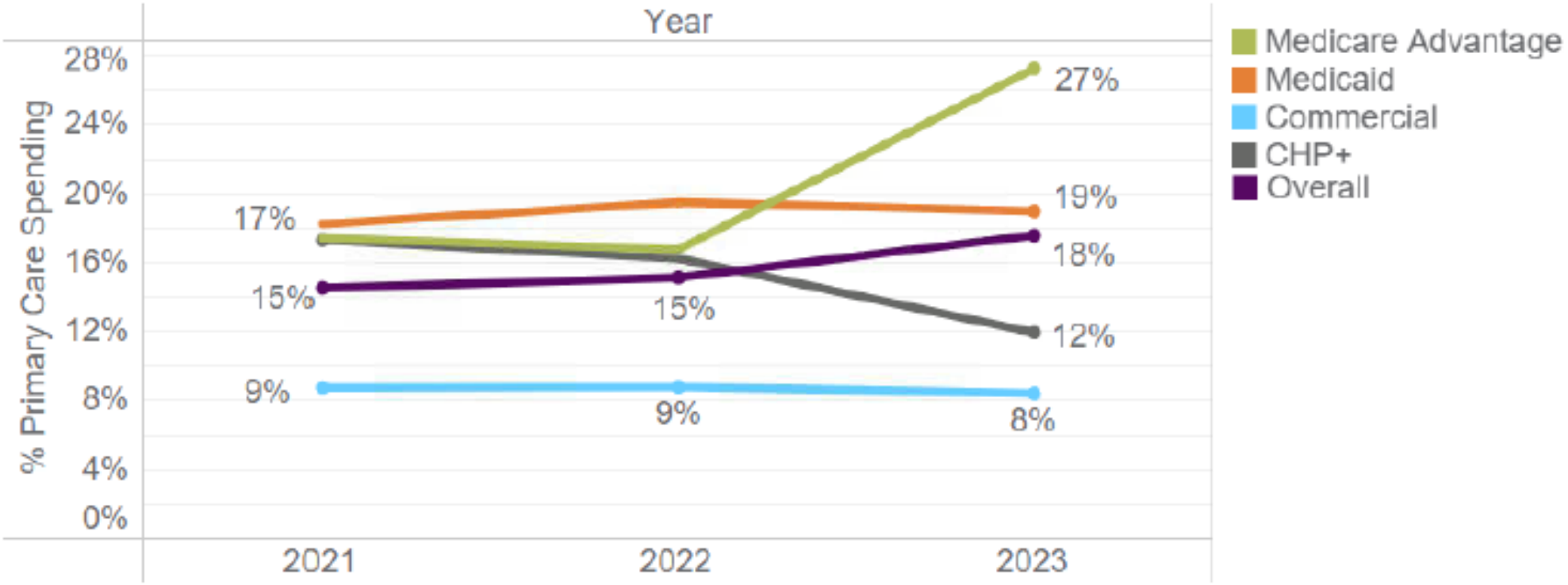
- An APM contract file is collected to describe the contract between carriers and providers and its HCP LAN category. Carriers provide details on:

| Category | Options |
|---|---|
| Mode of Payment | Claims, Non-Claims, or Both |
| Type of Services Paid | Specific medical services, Non-medical services, Comprehensive medical services |
| Timing of Payments | Prospective with retrospective reconciliation, Prospective without reconciliation, Retrospective |
| Population-based Payment | Yes/No |
| Provider Risk | Upside, Downside, Both, N/A |
| Quality Measurement | Yes/No |
| Target Spending | Yes/No |

# Primary Care Spending as a Percentage of Total Medical Spending by Line of Business: 2021-2023

Overall, the percentage of total medical spending, excluding Kaiser and Denver Health, attributed to primary care has increased from 15% in 2021 to 18% in 2023.

**Figure 1: Percent of Primary Care Spending by Payer Over Time, 2021-2023**





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# Primary Care Spending as a Percentage of Total Medical Spending: 2023

**Figure 2: Share of Primary Care Spending, 2023.**

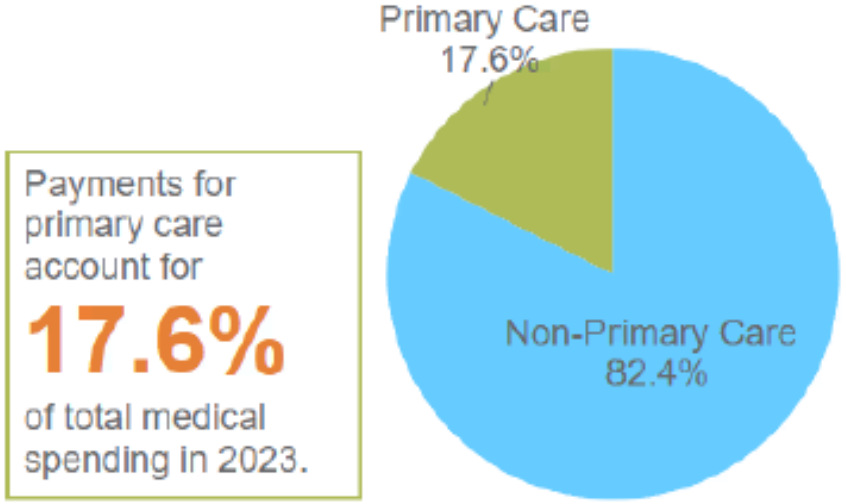
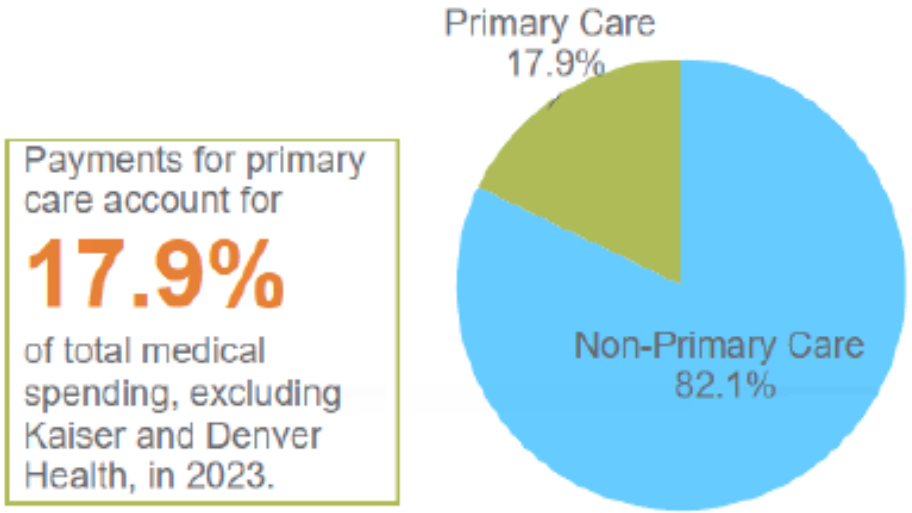



**Figure 3: Share of Primary Care Spending, excluding Kaiser and Denver Health, 2023.**




Notes:
(1) Total Medical Spending does not include dental and pharmacy spending
(2) Kaiser Permanente and Denver Health are not currently subject to the required targets for primary care investment established through Colorado Regulation 4-2-72 due to their unique integrated payer-provider systems.

# APM Spending as a Percentage of All Medical Spending: 2023

**Figure 6: Share of Total Medical Spending by APM Category, 2023.**

Payments under value-based alternative payment models account for

**34.8%**

of **total medical spending** in 2023.

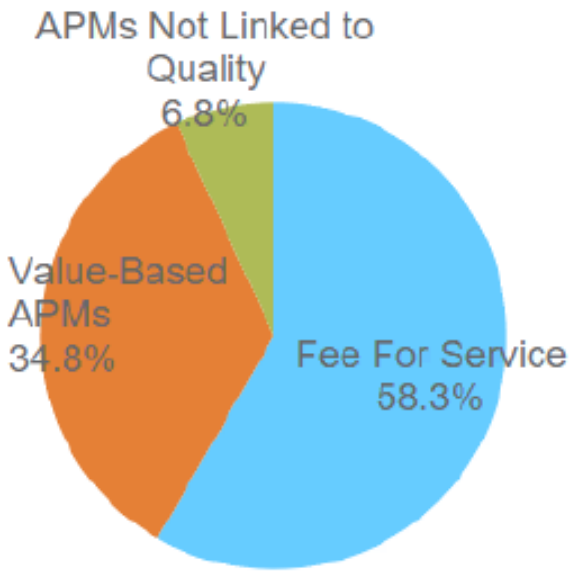
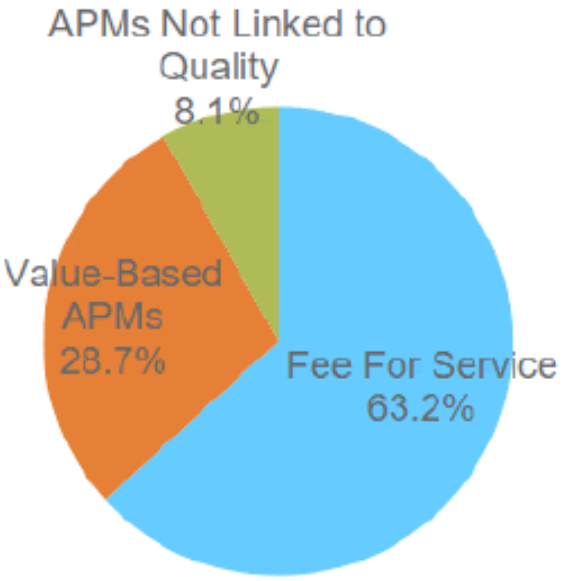



**Figure 7: Share of Total Medical Spending by APM Category, excluding Kaiser and Denver Health, 2023.**

Payments under value-based alternative payment models account for

**28.7%**

of **total medical spending**, excluding Kaiser and Denver Health, in 2023.




Notes:
The denominator (total medical spending) does not include pharmacy expenditures.
Value-based APM arrangements do not include risk-based payments and capitated payments not linked to quality (3N and 4N HCP LAN categories respectively).

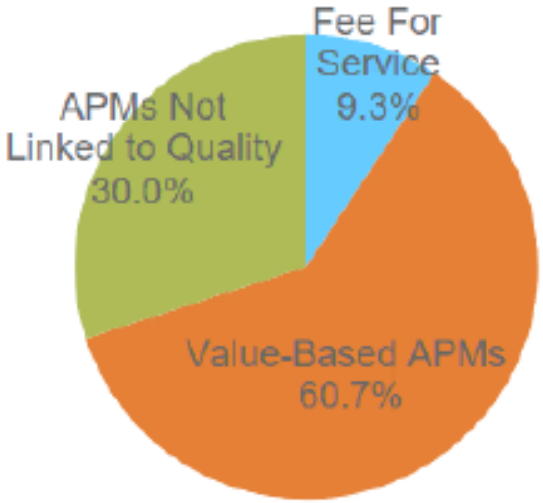
# Alternative Payment Models (APM) as a Percentage of Primary Care Spending: 2023

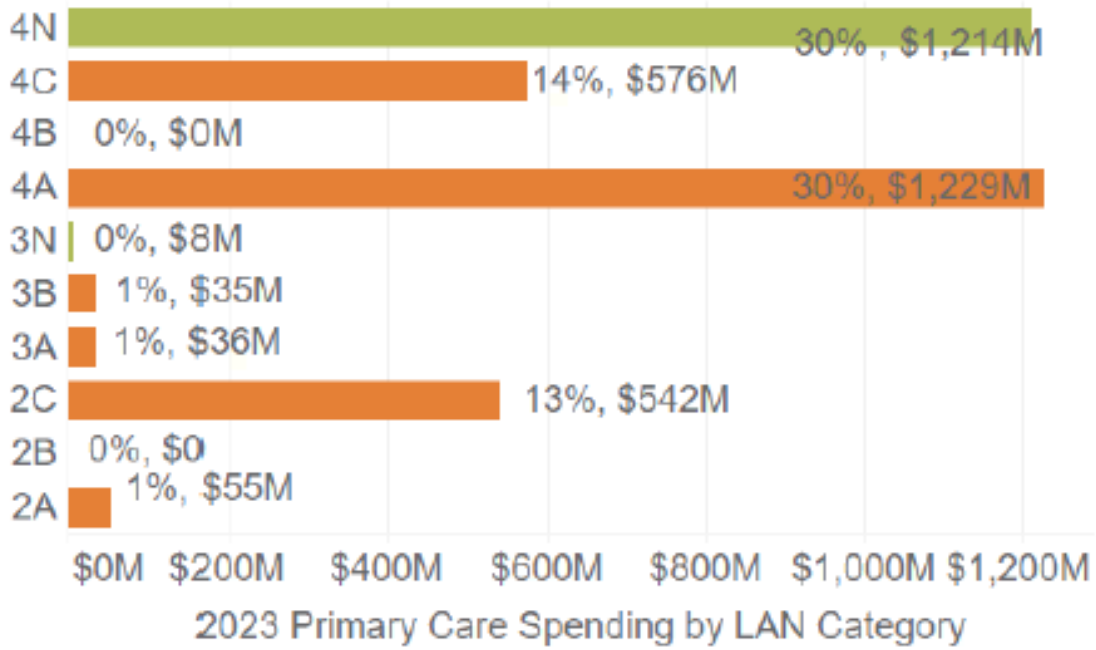
**Figures 4: Share of Primary Care Spending by APM Category, 2023.**

Payments under value-based alternative payment models account for

**60.7%**

of total **primary care spending** in 2023.




Note: Value-Based APMs include LAN Category 2, 3, and 4 payments, with the exception of 3N and 4N (payments with no link to quality)

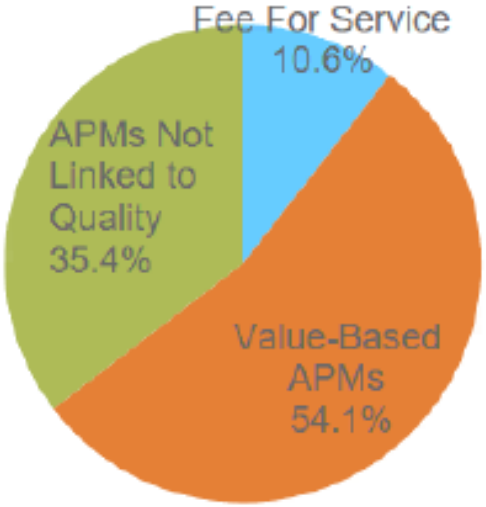
# APM as a Percentage of Primary Care Spending, excluding Kaiser and Denver Health: 2023

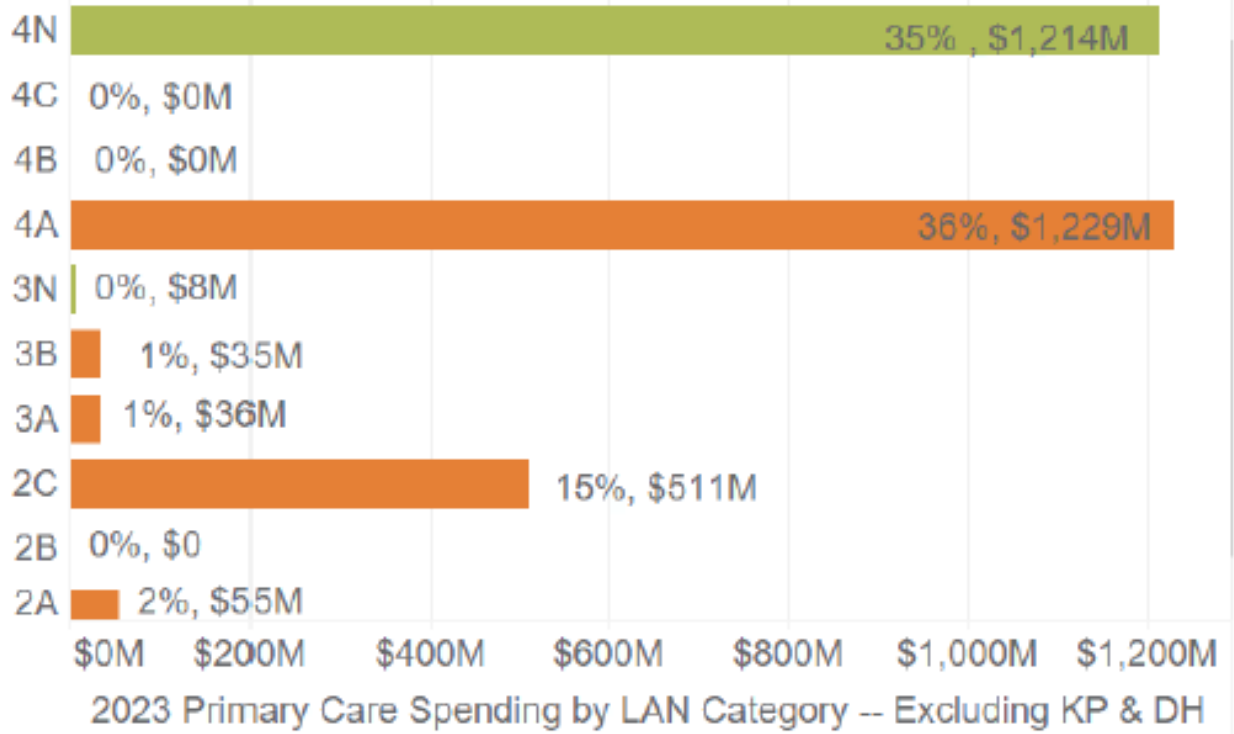
**Figure 5: Share of Primary Care Spending by APM Category, excluding Kaiser and Denver Health, 2023.**

Payments under value-based alternative payment models account for

**54.1%**

of total **primary care spending**, excluding Kaiser and Denver Health, in 2023.




Note: Value-based APM arrangements do not include risk-based payments and capitated payments not linked to quality (3N and 4N HCP LAN categories respectively).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# Prospective Payments as a Percentage of Total Medical Spending: 2023

**Figure 12: Share of Prospective Payments out of Total Medical Spending, excluding FFS, 2023.**

Prospective payments under alternative payment models account for

**52.0%**

of **total medical spending** in 2023.

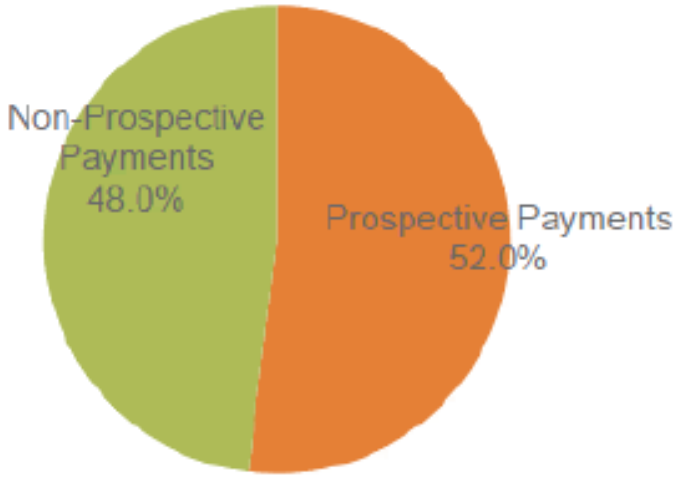
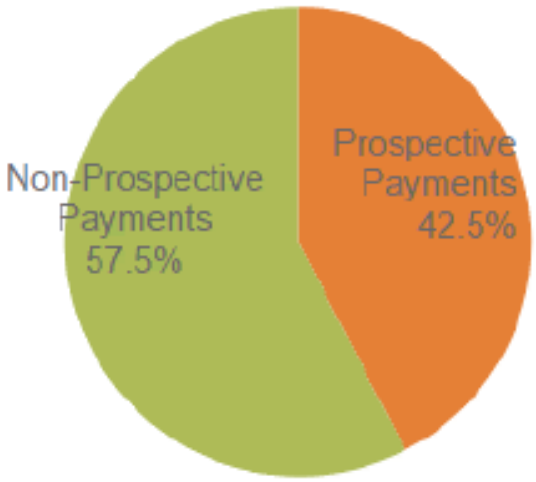



**Figure 13: Share of Prospective Payments out of Total Medical Spending, excluding FFS, excluding Kaiser and Denver Health, 2023.**

Prospective payments under alternative payment models account for

**42.5%**

of **total medical spending**, excluding Kaiser and Denver Health, in 2023.



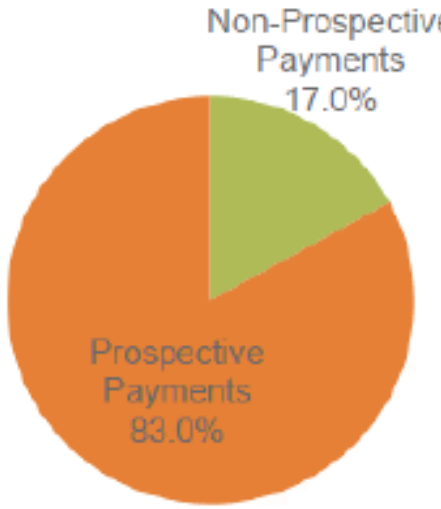
# Prospective Payments as a Percentage of Primary Care Spending: 2023

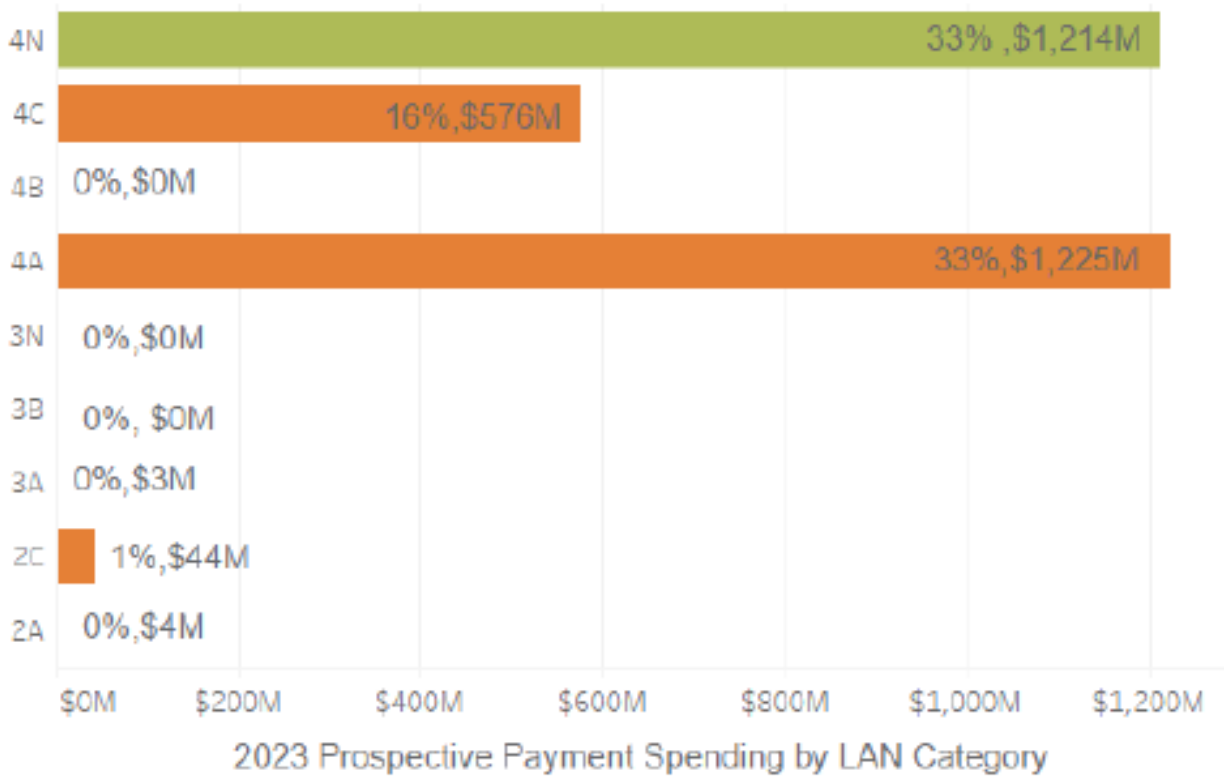
**Figure 10: Share of Prospective Payments out of Primary Care Spending, excluding FFS, by APM Category, 2023.**

Prospective payments under alternative payment models account for

**83.0%**

of total **primary care spending** in 2023.



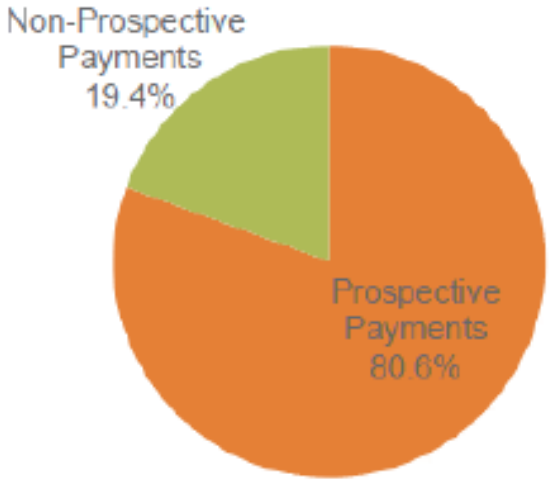
# Prospective Payments as a Percentage of Primary Care Spending excluding Kaiser and Denver Health: 2023

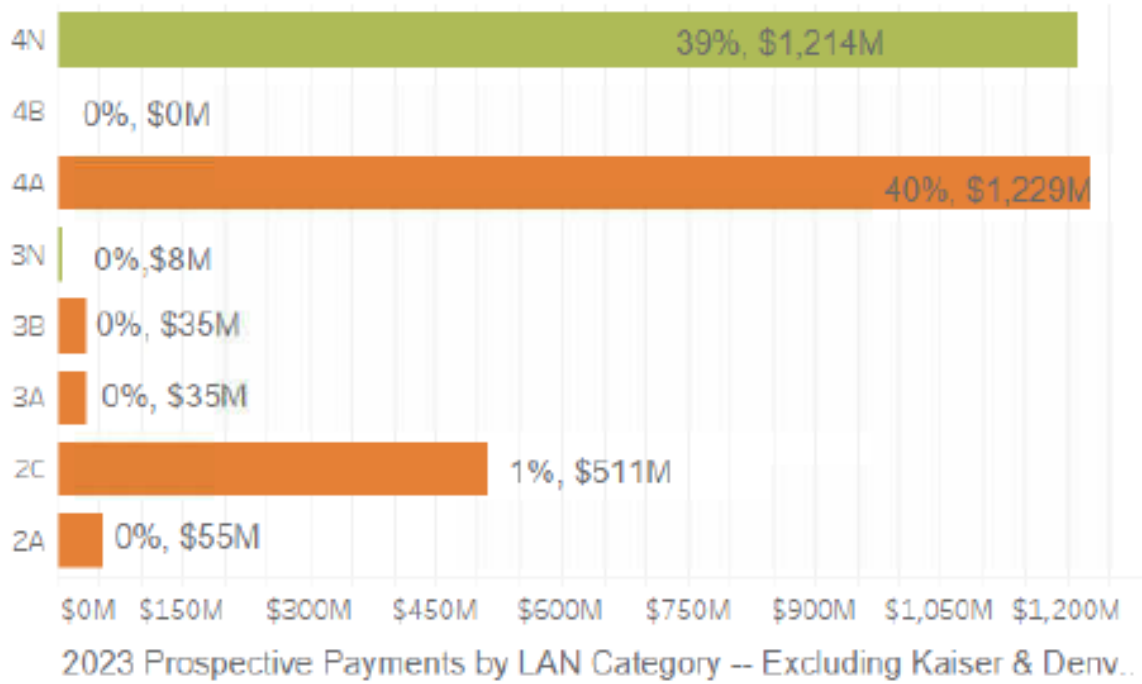
**Figure 11: Share of Prospective Payments Out of Primary Care Spending, excluding FFS, by APM Category, excluding Kaiser and Denver Health, 2023.**

Prospective payments under alternative payment models account for

**80.6%**

of total **primary care spending**, excluding Kaiser and Denver Health, in 2023.



# Limitations

- Resource constraint from payers presented challenges with submission logic and validation feedbacks
- Multiple entities/teams reviewing data at different times on the payer's side caused timeline issues
- Complexities of APMs data collection
  - Based on last year's learning, some payers re-evaluated their APM categories
  - Need to continue year-round outreach with payers around APM categories criteria and PMPM calculations
- Challenges in validating APM data with CO APCD data
- Primary care definition's reliance on provider taxonomies
  - No clear methodology to identify portion of capitated payments designated for primary care
  - Primary care designation varies by payer
  - Continue investigation on primary care designation comparisons with payers with large differentials
- Medicaid
  - Payers only reported payments they made directly to providers, this avoids duplicating payments going from HCPF to RAE/MCO organizations

# Next Steps

- Continue working with payer representatives to ensure accurate reporting
  - Use various payer forums to talk about APM data collection and criteria used to identify APM categories
  - Continue improving data collection process by clarifying instructions on data fields and contract supplement
- Investigate and add as needed new primary care codes
- Plan for incorporating Capitation File data into the annual reporting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Questions?

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# NASEM Standing Committee on Primary Care

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# *Introducing the National Academies of Sciences, Engineering, and Medicine (NASEM) Standing Committee on Primary Care*

*Lauren S. Hughes, MD, MPH, MSc, MHCDS, FAAFP*

*State Policy Director, Farley Health Policy Center, University of Colorado*

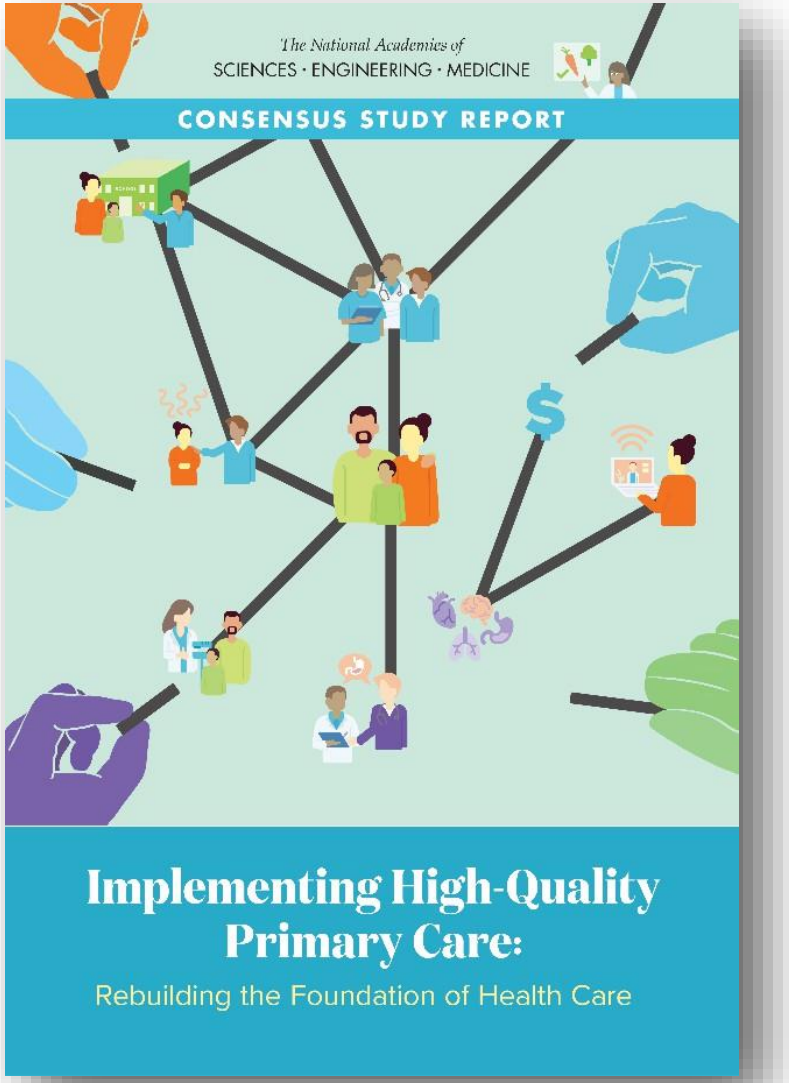
*Co-chair, NASEM Standing Committee on Primary Care*

***Acknowledgment:*** *Robert L. Phillips, Jr., MD, MSPH, Founding Executive Director, The Center for Professionalism and Value in Health Care*

# The National Academies

Private, nonprofit institutions that provide independent, objective analysis and advice to the nation to solve complex problems and inform public policy decisions related to science, technology, and medicine.

# Implementing High-Quality Primary Care (NASEM, 2021)




NATIONAL ACADEMIES Sciences Engineering Medicine

# Consensus study context

The Washington Post
Democracy Dies in Darkness

**Primary care saves lives. Here's why it's failing Americans.**

By Frances Stead Sellers

October 17, 2023 at 6:00 a.m. EDT

Primary care is the only part of health care system that results in **better health outcomes** and **greater health equity.**

It is **weakening** when it is needed most, stemming from decades of chronic underinvestment.

Primary care is **inaccessible** for large portions of the population.

**Visits to primary care are in decline,** and the workforce is shrinking.

**Innovative delivery models exist**, but they can be difficult to replicate and spread.

# An updated definition of primary care

High-quality primary care is the provision of whole- person, integ
accessible, and equitable health care by interprofessional teams
accountable for addressing the majority of an individual's health a
needs across settings and through sustained relationships with p
families, and communities.

# 5 Objectives for Achieving High-Quality Primary Care

1 PAYMENT
**Pay for primary care teams to care for people, not doctors to deliver services.**

2 ACCESS
**Ensure that high-quality primary care is available to every individual and family in every community.**

3 WORKFORCE
**Train primary care teams where people live and work.**

4 DIGITAL HEALTH
**Design information technology that serves the patient, family, and interprofessional care team.**

5 ACCOUNTABILITY
**Ensure that high-quality primary care is implemented in the United States.**

NATIONAL ACADEMIES Sciences Engineering Medicine

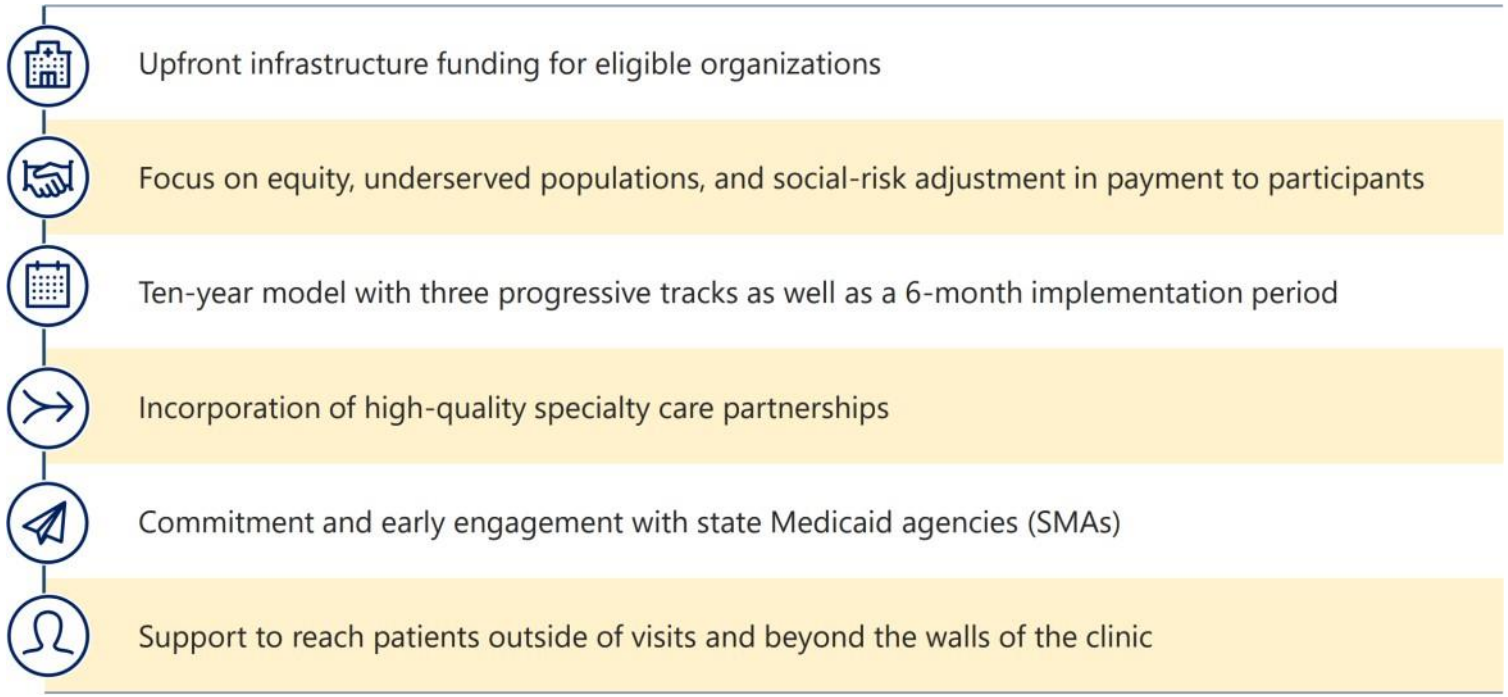
# **Objective 1:** Pay for primary care teams to care for people, not doctors to deliver services

**Action 1.1**: Payers should evaluate and disseminate payment models based on their ability to promote the delivery of high-quality primary care.

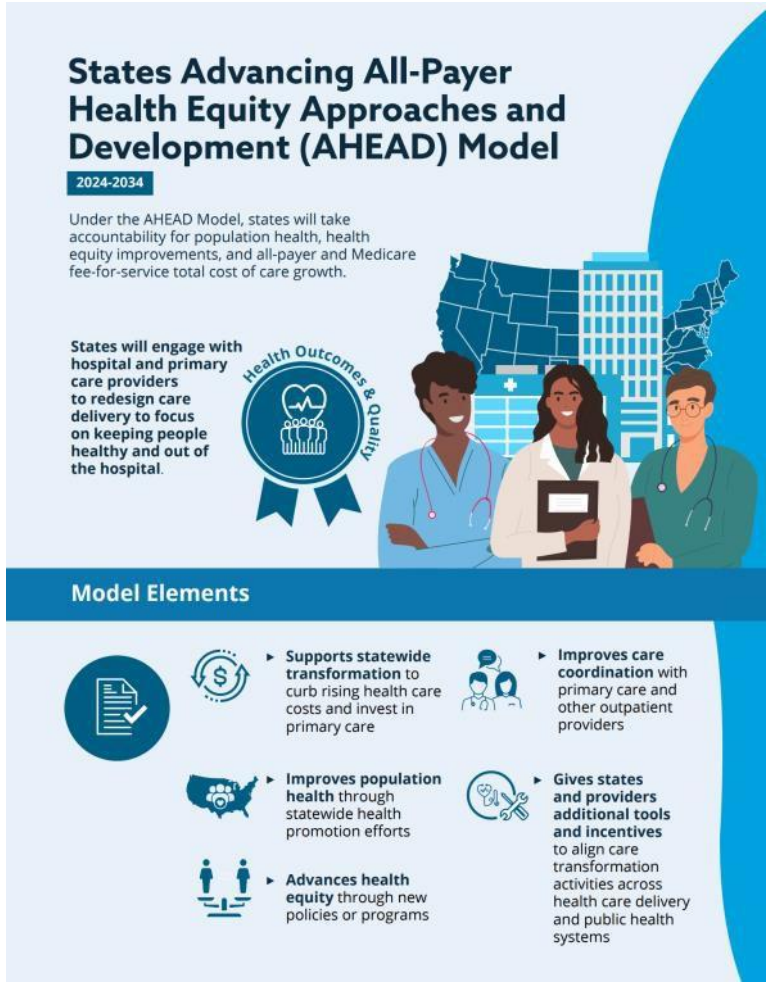
**Action 1.2**: Payers using fee-for-service models for primary care should shift toward hybrid reimbursement models.

# Making Care Primary now live in eight states

- Overarching goal is to move practices from FFS to prospective, population-based payments that support comprehensive, integrated primary care
- Focus on small, independent, rural, safety net practices, including those new to value-based care
- Payers are partnering to align on areas to reduce provider burden
- ***Key design features:***



# Three cohorts are participating in AHEAD




- Overarching goal is to partner with states to curb health care cost growth, improve population health, and advance health equity
- Builds on existing CMMI state-based models in Vermont, Maryland, and Pennsylvania
- 11-year, all-payer model
- AHEAD model participants will be held accountable for state-specific Medicare and all-payer cost growth and primary care investment targets
- Primary care component of the model will align with state-level Medicaid transformation efforts and improve team-based care, care management, and behavioral health

IN THE SENATE OF THE UNITED STATES

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Mr. WHITEHOUSE (for himself and Mr. CASSIDY) introduced the following bill; which was read twice and referred to the Committee on

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# A BILL

To provide for the establishment of hybrid primary care payments under the Medicare program, and for other purposes.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE.**

This Act may be cited as the "Pay PCPs Act of 2024".

**SEC. 2. FINDINGS.**

Congress makes the following findings:

(1) Transformation of primary care practices serves as an essential foundation for improving

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# Medicare Physician Fee Schedule Final Rule Summary: CY 2025

| | |
|---|---|
| **Related CR Release Date:** November 21, 2024 | **MLN Matters Number:** MM13887 |
| **Effective Date:** January 1, 2025 | **Related Change Request (CR) Number:** CR 13887 |
| **Implementation Date:** January 6, 2025 | **Related CR Transmittal Number:** R12975CP |
| **Related CR Title:** Summary of Policies in the Calendar Year (CY) 2025 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List | |

**Action 1.3**: CMS should increase overall portion of primary care spending by improving Medicare fee schedule and restoring the RVS Update Committee to advisory nature.

**Action 1.4**: States should facilitate multi-payer collaboration and increase the portion of health care spending for primary care.

# The Standing Committee on Primary Care is examining alternative ways to valuate primary care

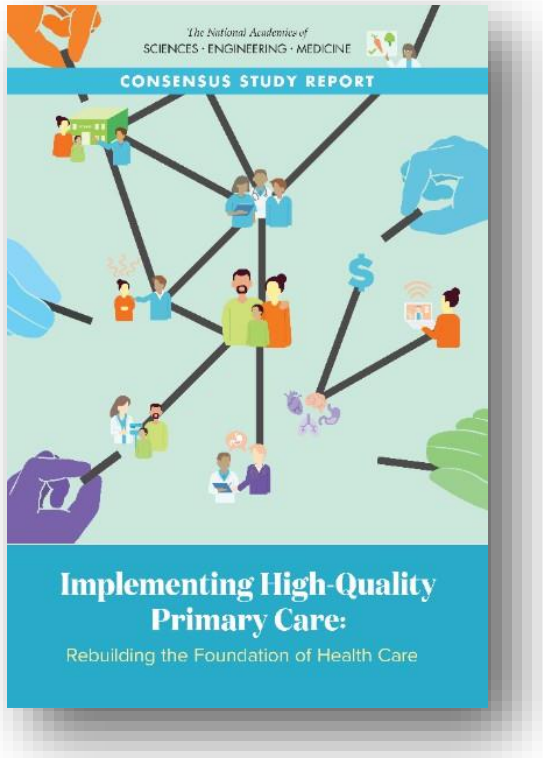
# AHRQ issues technical brief on primary care spend


- 67 estimates of primary care spending identified
- Single estimates for primary care spending (without specifying na range from 5.1 – 10.3% of total healthcare spending
- Estimates vary widely based on different definitions of primary ca payments, payers, and patients are included
- To improve primary care spending estimates:
  - Develop a consensus definition of primary care
  - Establish consistent methods to measure and collect data and to attr care
  - Create standards for transparent reporting of methods and decisions that impact estimates

# **Objective 5:** Ensure that high-quality primary care is implemented in the United States

**Action 5.1**: The HHS Secretary should establish a Secretary's Council on Primary Care to coordinate primary care policy, ensure adequate budgetary resources for such work, report to Congress and the public on progress, and hear guidance and recommendations from a Primary Care Advisory Committee that represents key primary care stakeholders.

# Implementing High-Quality Primary Care (NASEM, 2021)




## Recommendation 5.1:

Secretary's Council on Primary Care → Initiative to Strengthen Primary Health Care

Primary Care Advisory Committee → NASEM Standing Committee on Primary Care

NATIONAL ACADEMIES Sciences Engineering Medicine

# HHS Issue Brief

**ISSUE BRIEF**

November 7, 2023

## HHS IS TAKING ACTION TO STRENGTHEN PRIMARY CARE

The U.S. Department of Health and Human Services (HHS) is taking action to strengthen primary care. Recognizing the importance of having a strong primary care foundation to our healthcare system, HHS collaborated across Divisions to develop a coordinated set of actions to strengthen primary care in our nation and has moved forward with implementing these actions. This issue brief outlines the critical actions that HHS has taken and its future work to strengthen primary care. In addition to sharing HHS primary care activities, with this issue brief, HHS aims to foster collective action among stakeholders and across the healthcare system and other sectors. Together, we can maximize individual and population health and well-being; ensure access to affordable, comprehensive, whole person primary care throughout the country; and make it possible for all communities to be served by trusted primary care clinicians and multidisciplinary teams who reflect the communities they serve.

### OVERVIEW & SCOPE OF PROBLEM

HHS recognizes that effective primary care is essential for improving access to healthcare, for the health and well-being of individuals, families, and communities, and for achieving health equity.

By strengthening primary care, HHS will help advance the Department's strategic goals. Strong primary care is also essential for addressing other HHS priority focus areas, such as: addressing the overdose epidemic and the mental health crisis, improving maternal health, and reducing disparities in maternal mortality and morbidity in our nation.

It is well documented that health systems with a strong base of primary care provide better access to health services, and have improved health outcomes, lower mortality, and more equity. In addition, effective primary care can result in cost savings. In 2022, Accountable Care Organizations (ACOs) in the Medicare Shared Savings Program that were categorized as low revenue (mainly physician- led) and comprised of 75% or more primary care clinicians, saw more than two times net savings compared to


HHS Primary Care Dashboard Project
NASEM - Standing Committee Briefing
September 18, 2024
OASH
Office of the Assistant Secretary for Health
ASHLIN Management Group
The ASHLIN [illegible] was funded through a contract 75P00122F37001 with the Department of Health and Human Services (HHS) Office of the Assistant Secretary for Health (OASH).
David Wong
Play
2:19:20
vimeo

# Standing Committee on Primary Care: Statement of Task

- NASEM will establish a standing committee of experts in primary care delivery, research, and policy to help inform the Initiative to Strengthen Primary Health Care, a coordinated activity across agencies within the Federal Government.
- The Standing Committee will maintain surveillance of the primary care field.
- The Standing Committee may issue letter reports in response to direct questions from sponsors.

# How the Standing Committee Does Its Work

- Two main public work streams: meetings and publications focused on advising federal actions
  - Publications can include policy recommendations for Federal agencies or other
- Areas of focus for 2024:
  - Payment
  - Workforce
- Funded for 3 years; 2 - 4 public meetings per year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Troubleshooting Tips
A MEETING
NATIONAL ACADEMIES Sciences Engineering Medicine
Standing Committee on Primary Care
May 2024 Public Meeting
May 20 · 9:00AM – 5:00PM ET
May 21 · 9:00AM – 1:00PM ET

# Identified Needs (Payment)

- What do primary care providers and practices, especially small and rural practices, need to join value-based models?
- Medicare Advantage is now half of the program. More data is needed on all fronts:
  - Cost, quality, and access for beneficiaries
  - Marketing practices
  - Delays and denials
- As more and more states are venturing into primary care spend, a common definition would be welcome. (Discussed during September public meeting)

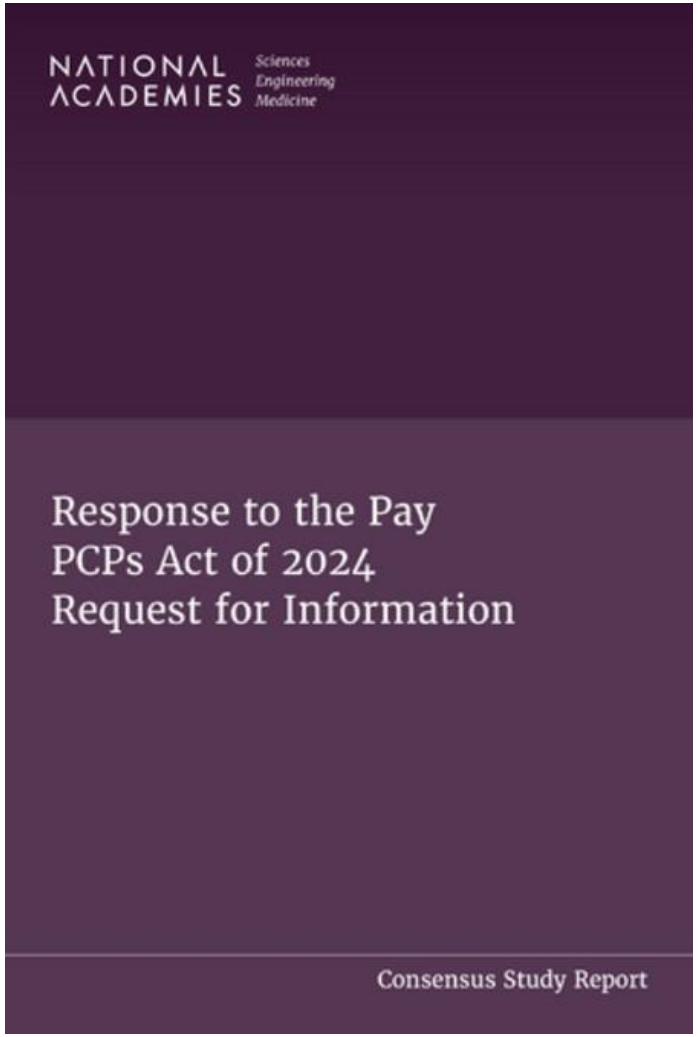
# Identified Needs (Payment)

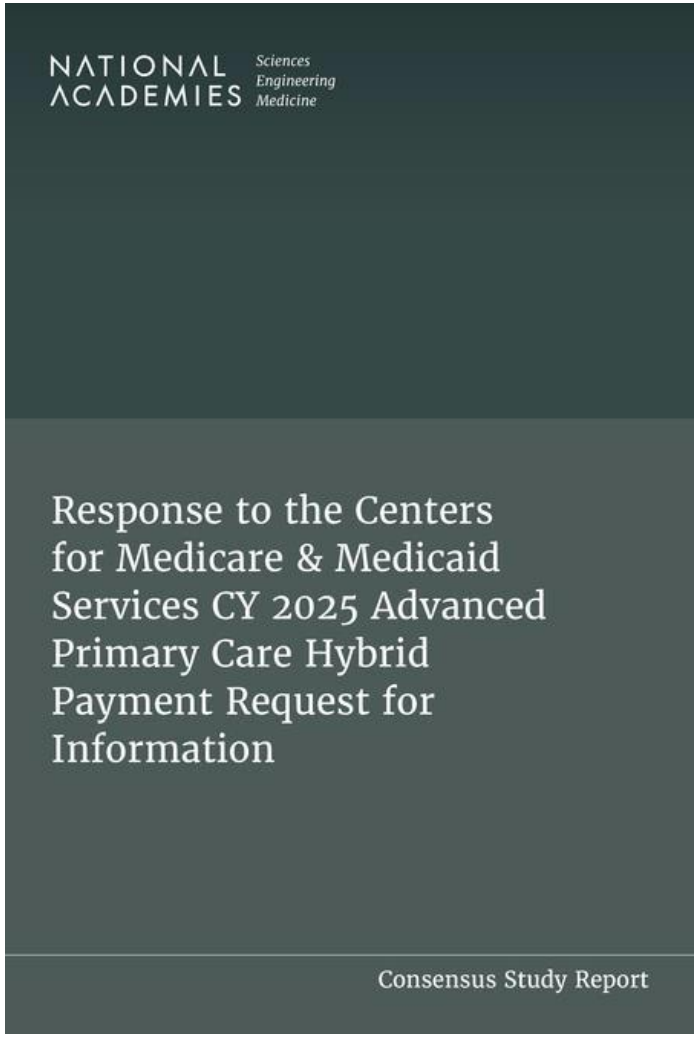
- Metrics alignment across payers is paramount.
- Work is needed on evaluating the valuation process for primary care, including better understanding the limitations of the current approach and identifying the time and effort required for interprofessional teams to deliver high-quality advanced primary care. What are the principles and processes for alternative inputs that still meet statutory requirements? (Publication in process, anticipated Q1 2025 release)
- Scaling and spreading of care models and new codes
  - Parts of (or entire) CMMI demonstrations
  - Capitalize on VA, payer learnings
  - Educate about new G codes for health-related social needs services

# Identified Needs (Workforce)

- Improving graduate medical education
  - CMS authority to track outcomes and how these $$$ are spent
  - Funding that follows trainees, rather than institutions
  - Sharing teaching health center GME results (+ needs permanent funding)
  - Identifying community-based sites with enough capacity to welcome learners (Both points discussed during the November public meeting)
- Interprofessional primary care teams
  - Composition
  - Training
  - Payment (form, amount, and flow)
  - Data clarity and comprehensiveness

# RFI Responses Point to the Need for Payment Reform



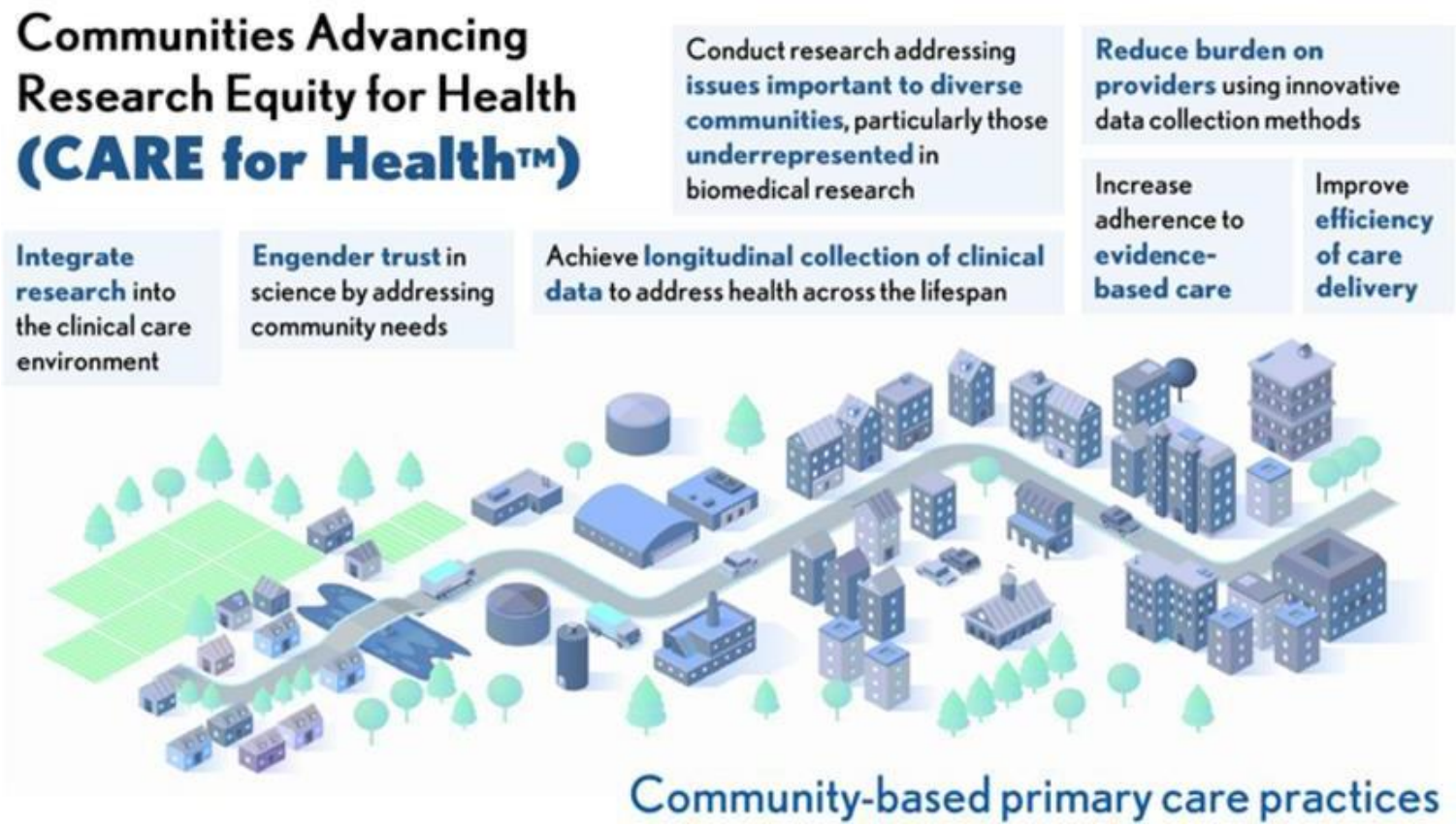



**Action 5.2**: HHS should form an Office of Primary Care Research at NIH and prioritize funding of primary care research at AHRQ.

- AHRQ's National Center for Excellence in Primary Care Research received its first funding ever in FY22 of $2 million.
- HHS Primary Care Dashboard proposes two measures re: NIH and federal dollars going into primary care research.

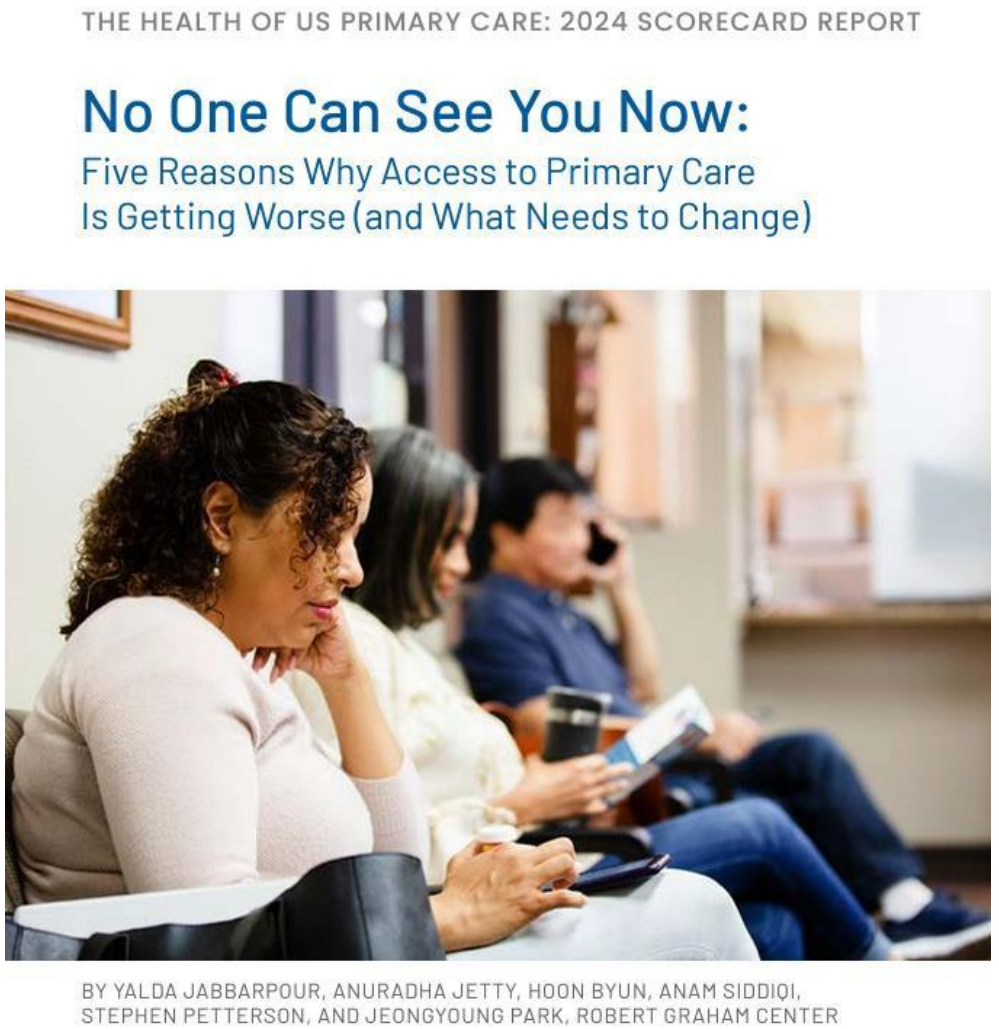
**Action 5.3**: Primary care professional societies, consumer groups, and philanthropies should assemble, regularly compile, and disseminate a "**High-quality primary care implementation scorecard**" to improve accountability and implementation.

# NIH launches CARE for Health™ initiative to expand frontline primary care research opportunities

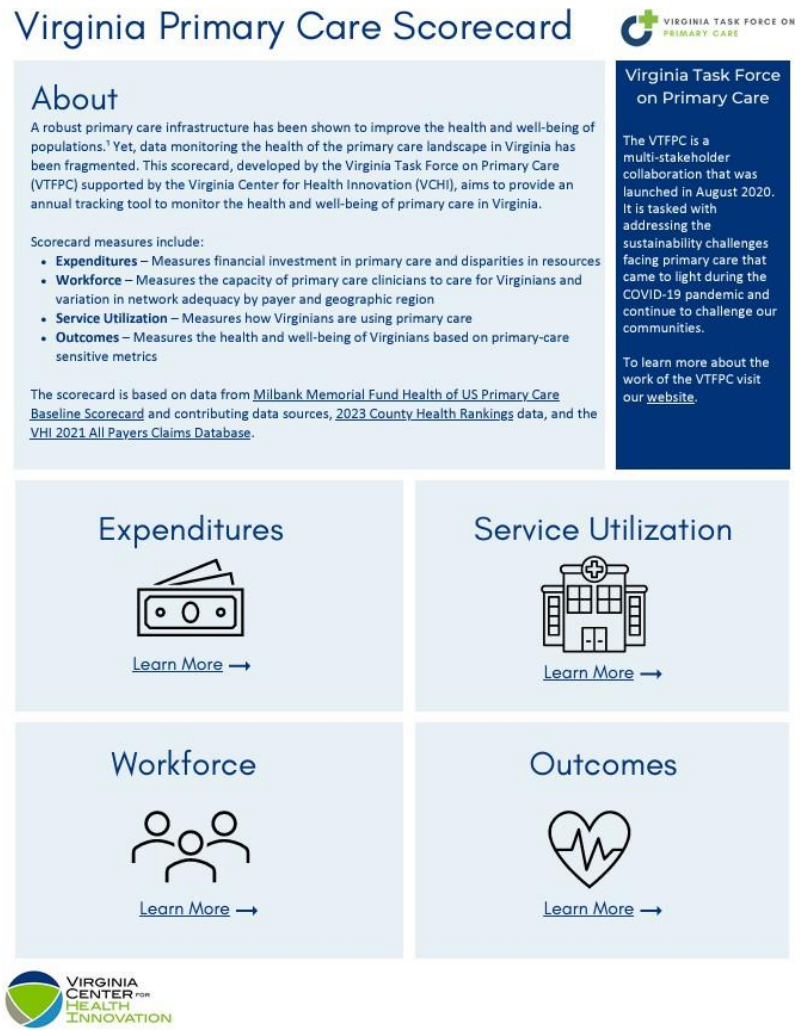


# Milbank Memorial Fund and Physicians Foundation partner with the Robert Graham Center on the second “Health of US Primary Care” scorecard

- The workforce is not growing fast enough
- The number of trainees entering and staying in primary care is too low – and not enough have community-based training
- The US continues to underinvest in primary care
- Technology has become an added burden in primary care
- Research to identify, track, and implement novel care delivery and payment solutions is lacking



# States are developing primary care scorecards





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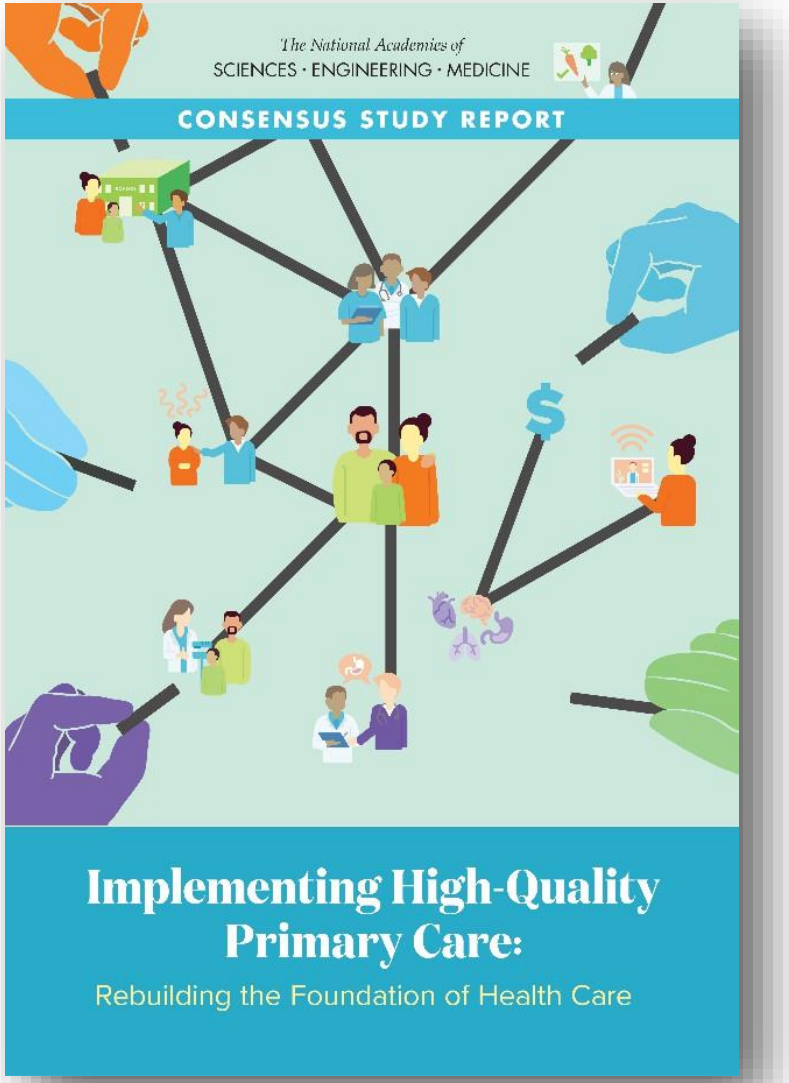
# Implementing High-Quality Primary Care (NASEM, 2021)

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# Thank you!

*Please reach out at lauren.hughes@cuanschutz.edu.*

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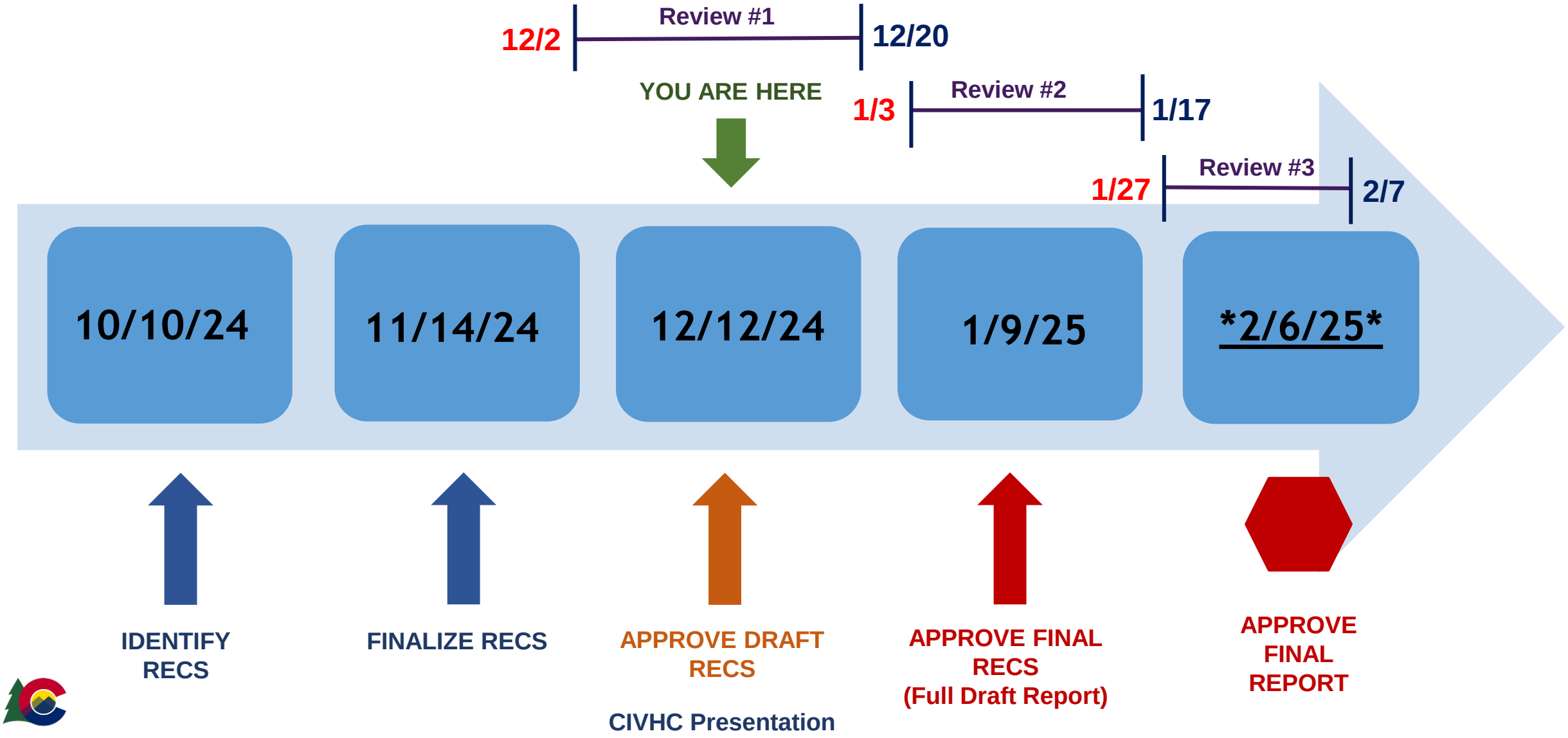
# Annual Report Timeline & Process

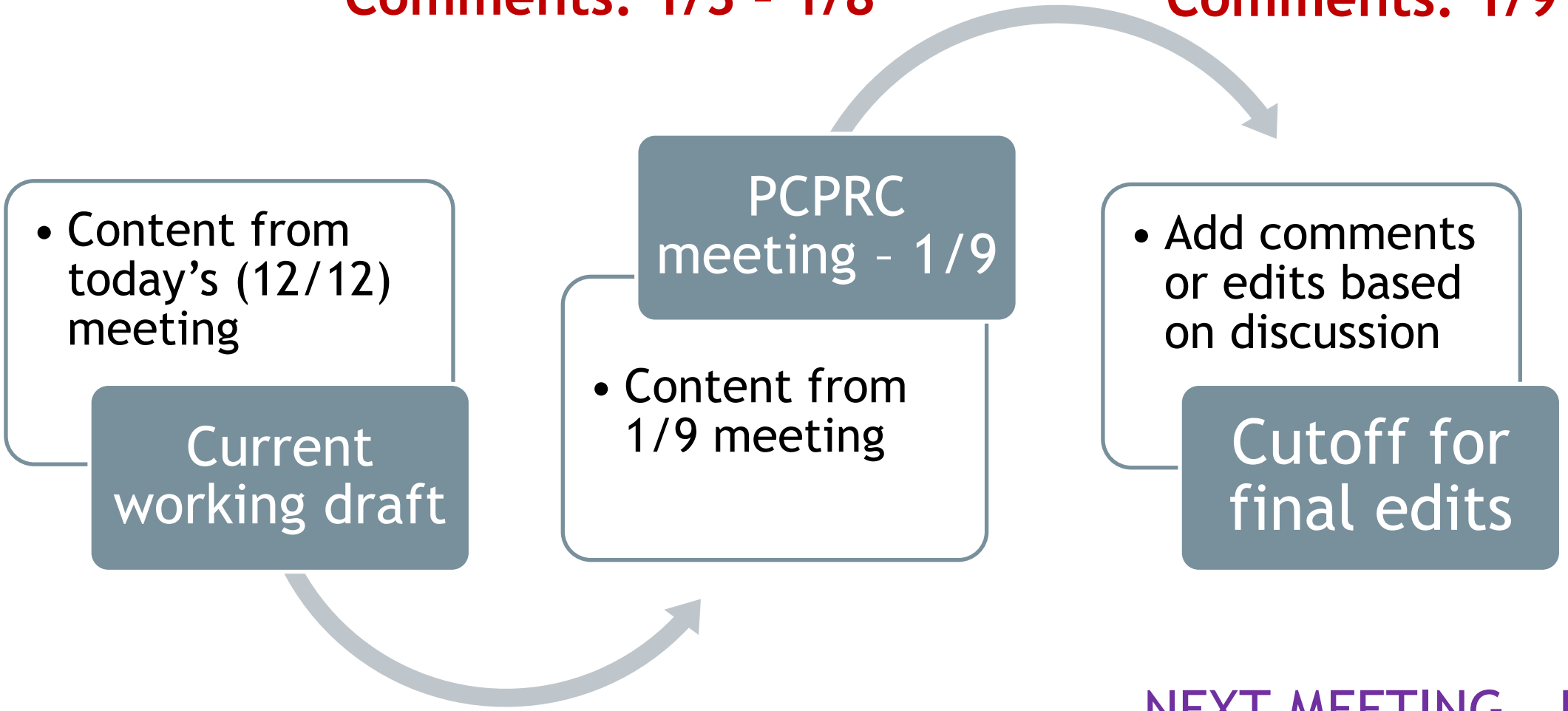
# Recommendations Report



# Review Period

**Comments: 1/3 - 1/8**

**Comments: 1/9 - 1/17**




**Comments: 12/12 - 12/20**

NEXT MEETING - Feb 6

# Annual Report Recommendations

# Organizational Structure

| | |
|---|---|
| Executive Summary | • Summary and recommendations |
| PCPRC Background | • Statutory charge<br>• Operations (report process/voting, membership) |
| Introduction | • Key themes |
| Recommendations | • Marketplace dynamics, AI, health equity |
| Conclusions | • Summation<br>• Next steps |

FUTURE WORK

# Executive Summary

- Executive summary
  - Reaffirm need to strength primary care
    - Through increased investment and adoption of value-based payments
    - To support and promote delivery of high-quality, person-centered care that improves health outcomes
  - This year's topics: marketplace dynamics, AI, health equity
- Previous recommendations have focused on strategies related to care delivery, including integrated care, and payment mechanisms
  - During that time, significant shifts in primary care landscape
  - Marketplace dynamics – impacts on providers, payers, and patients
  - AI – great promise, concerns re: how technologies developed and deployed

# PCPRC Background

- History
  - One of early leaders in this space (originally a handful, now 13+)
- Statutory charges
- Report process and voting
- Membership
- Sunset – include COPRRR summary?

# Introduction and Key Context

- Summary of previous reports – include at start or as an appendix?
- Additional investment needed because:
  - Workforce challenges
  - Affordability and access challenges
  - Continued need to address health equity
  - Tenuous financial state of rural and independent practices
  - Additional expectations placed on primary care providers
- PCPRC achievements
- National recognition
- Context/summary of marketplace dynamics, AI, health equity

# Recommendation #1 – Marketplace Dynamics

## Recommendation 1: Monitor the Impact ~~Landscape~~ of Marketplace Dynamics on ~~in~~ Colorado's Primary Care Practices

Marketplace dynamics that impact ~~of~~ primary care practices, particularly consolidation and private equity investments, should be monitored in Colorado. These dynamics have a direct impact on the quality and cost of healthcare. Understanding marketplace trends is needed to support the primary care workforce and inform future investments in primary care infrastructure.

# Recommendation #1 – Marketplace Dynamics

- Consolidation and private equity
- Marketplace data and trends
- Understanding the Colorado landscape
- Negative impacts on payers, providers, and patients
  - Cost of care
  - Quality of care
  - Provider and practice experience
- Role of value-based payment

# Recommendation #1 – Marketplace Dynamics

MISCELLANEOUS

- ACOs - benchmarking, attribution, HRSN, pediatrics
- Independent primary care - additional payments, upfront capital for "low-revenue" physician led ACOs, reduce threshold of minimum covered beneficiaries
- Multiple CMMI models

# Recommendation #2 – Artificial Intelligence (AI)

## Recommendation 2: Ethical and Equitable Adoption of Artificial Intelligence

New technology, including artificial intelligence (AI) tools, should be thoughtfully adopted into the primary care setting. Valid concerns about AI accuracy, impacts on practice workflow, and consent over the rapid adoption of this technology should be meaningfully addressed before the technology is [adopted, incorporated] ~~standardized~~.

# Recommendation #2 – Artificial Intelligence (AI)

- Emergence of AI – add definitions of types of AI ?
- Easing administrative burden
- Accuracy and bias – mention SB21-169, NAIC ?
- Inequitable uptake of AI technology
- Patient consent and engagement
- Payment considerations

# Recommendation #3 – Health Equity

## Recommendation 3: Evaluate the Progress of Payment Models in Driving Health Equity Actions

Payment models should drive meaningful actions to address health equity. This includes incentivizing evidence-informed actions that improve the quality of care and lead to a reduction in disparate health outcomes. The extent to which payment models are successful in addressing disparities and directing quality improvements in health care should be tracked.

# Recommendation #3 – Health Equity

- Focusing on health equity in payment
  - Data collection
  - Support for culturally responsive care
- Accountability for health equity
  - Elevate the voices of individuals and families alongside experts in the health care field
  - Incentivize action to reduce disparities
  - Focus on whole-person and whole-family care – tie to last year's report ?
- Examples of infrastructure to track progress
  - National example
  - Michigan example
- Role of the Collaborative

# Future Work

- Utilize APCD to better understand state of APM reporting and impacts
  - Measure progress in adopting APMs in primary care setting
  - Measure and track primary care spending – other? (workforce, etc.)
- Increase data transparency
  - Sharing data about [value-based payments, other?] in public dashboard
- Explore other important topics as they arise

# Additional/Miscellaneous

- Communicating importance of high-quality primary care
  - NASEM report – continuing the drumbeat
  - Messaging around APMs – patients/consumers, legislators
- Measuring investments & impact on outcomes
  - Are payments going to the right places – care transformation measures
  - Dashboards, score cards – NASEM, Milbank; other states
  - Investment vs spend on primary care
- ACOs – benchmarking, attribution, HRSN, pediatrics
- Independent practices– addn payments, upfront capital for “low-revenue” physician led ACOs, minimum covered beneficiary thresholds
- Multiple CMMI models

# Graphics Check-In

- Appendix B
- Primary care landscape
  - CMMI models
  - ACOs
  - HCPF – ACC 3.0, APMs (PACT), 1302 grants and report
  - Integrated delivery systems
- Types of consolidation

# CMMI Models

## ACO Realizing Equity, Access, and Community Health (ACO REACH)

- **Encourages health care providers — including primary and specialty care doctors, hospitals, and others — to come together to form an Accountable Care Organization, or ACO.**
- **Breaks down silos and delivers high-quality, coordinated care** to patients that improves health outcomes and manages costs.
- **Addresses health disparities** to improve health equity.

**2021 - 2026**

## Primary Care First (PCF)

- **Supports primary care practices** in managing their patients' health — especially patients with complex, chronic health conditions.
- **Enables primary care providers to offer a broader range of health care services** that meet the needs of their patients. For example, practices may offer around-the-clock access to a clinician and support for health-related social needs.

**2021 - 2026**

## Making Care Primary (MCP)

- **Improves care management, community connections, and care integration** by providing capacity building resources to those new to value-based care.
- **Increases access to care and creates sustainable change in underserved communities** by facilitating partnerships with state Medicaid agencies, social service providers, Federally Qualified Health Centers (FQHCs) and specialty care providers.

**2024 - 2034**

## States Advancing All-Payer Health Equity Approaches and Development (AHEAD)

- **Creates a new pathway to invest in primary care** via statewide primary care investment targets.
- **Provides Enhanced Primary Care Payments** to increase investment in primary care.
- **Uses a flexible framework of care transformation activities** to align with existing Medicaid value-based-payment arrangements.

**2024 - 2034**

## ACO Primary Care Flex (ACO PC Flex)

- **Focuses on improving funding and other resources** to support primary care delivery in the Medicare Shared Savings Program.
- **Utilizes a flexible payment design** to empower participating ACOs and their primary care providers to use more innovative, team-based, person-centered and proactive care approaches.
- Incentivizes the **development of new ACOs**, particularly those that will support underserved communities, and addresses health disparities.

**2025 - 2030**

# Medicare & State ACOs

- Medicare Shared Savings Program
- Community Health Provider Alliance
- Clinical Partners of Colorado Springs
- Banner Health Network
- HealthONE Colorado Care Partners

# Public Comment

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# Thank you!!

# Future Work

- Consult with DPA, HCPF, and CIVHC
- Advise in development of affordability standards and **targets for investment in primary care**
- In coordination with CIVHC, **analyze the % of medical expenses allocated to primary care**
- Develop a **recommendation on the definition** of primary care
- Report on current insurer practices and methods of reimbursement that direct greater resources and investments toward innovation and care improvement in primary care
- **Identify barriers to the adoption of APMs** by health insurers and providers, and develop **recommendations to address**

- Develop recommendations to increase the use of APMs that are not paid on FFS basis to:
  - Increase investment in advanced primary care delivered by practices that are PCMHs (state or national criteria) or have demonstrated ability to provide high-quality primary care
  - **Align primary care reimbursement** by all consumers of primary care
  - Direct investment toward higher value primary care services with an **aim toward reducing health disparities**
- Consider how to increase investment in advanced primary care without increasing costs to consumers or total costs of care
- Develop and share best practices and technical assistance to insurers and consumers
  - **Aligning quality metrics** as developed in SIM
  - Facilitating **behavioral and physical care integration**
  - **Practice transformation**
  - The delivery of advanced primary care that facilitates appropriate utilization of services in the appropriate setting

# Data – Second Annual Report

- Data collection at the plan, health system, and practice-level should allow analysis of racial and ethnic disparities
  - To degree data sources exist, often isolated and incomplete
  - Strategies to improve data collection should be multifaceted and address a variety of questions:
    - Who is collecting the data?
    - Who will it be shared with and why?
    - How will it be shared?
- Predicated on trust; require relationship building, open and transparent communication about needs and uses of such data

# Data – Second Annual Report

- Types of data that should be collected:

| | |
|---|---|
| **Accessibility** | • Data on social risk factors and underlying drivers crucial to understanding and addressing causes of poor health outcomes<br>• Increased investments and APMs can play key role by supporting strategies that increase access (extended office hours)<br>• Payers and providers can engage with policymakers to develop solutions |
| **Health Outcomes** | • Data on social risk factors less available, if at all<br>• To develop payments structures, data need to be actionable and shared between payers and providers<br>• Intensely personal and sensitive; engage patients and communities |
| **Affordability** | • Affordability concerns often heightened for racial and ethnic minorities<br>• Data on health care affordability should be disaggregated by race and ethnicity and other demographic characteristics |