Primary Care Payment Reform Collaborative Meeting

September 12, 2024

Agenda

- Housekeeping & announcements
- Federal & state updates
- Annual Review of Aligned APM Parameters
- Equity, Market Dynamics, Measures
- Public comment

Meeting Goals & Requested Feedback

GOALS

- Discuss annual review process for aligned APM parameters
  - Process and timeline
  - Comments on current parameters
- Revisit discussion of health equity in APMs, and identify next steps
- Revisit discussion of market trends and systems in Colorado, and influence on flow of primary care dollars, and identify next steps

FEEDBACK

- How can/should DOI effectively engage stakeholders in annual review of aligned APM parameters?
- Interest in including updated recommendation(s) around health equity in this year's report?
- Next steps in drilling down on systems/structures in Colorado, or other approaches to identifying the flow of dollars?

* * Incorporate equity into discussion and recommendations * *

Draft Schedule

APRIL

Equity in APMs

MAY

Impact of venture capital, private equity, consolidation, integration on PC

Market Dynamics

SUMMER BREAK

JUNE

Flow of primary care dollars within/outside of "systems" (e.g., ACOs, FQHCs, IDS); rural, independent providers

AI IN PRIMARY CARE

JULY

Current state of PC investment (CO, other states, national)

PC Investment

AUG

Investment strategies- payment (APMS), infrastructure, team-based care, care coordination (HRSN)

SEPT

* * Review APM Parameters * *

Measurement, scorecard, communications

OCT

Identify recommendations

NOV

CIVHC Report/ Recommendations

DEC

Draft Recommendations

* * * DRAFT Proposal * * *

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Housekeeping & Announcements

Housekeeping & Announcements

- Meeting minutes – approval of August meeting minutes
- Primary care/APM reporting stakeholder discussion
  - Stakeholder discussion held on August 22
  - Next steps:
    - Division will resume rulemaking on 4-2-72; simultaneously release updated reporting template
    - Updates available on HB22-1325 website, Division email distribution list

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Federal & State Updates

Federal Updates

- Future of Telehealth and Its Impact on Primary Care – Health Affairs
  - Online Forum - Tuesday, September 24
  - Register: https://thewebinerd.zoom.us/webinar/register/WN_UALKnwixQji0GAwYYaW2Og#/registration
- HCPLAN Summit – November 14, 2024
  - Register: https://hcp-lan.us11.list-manage.com/subscribe?u=79339b7f02582ba86a0956046&id=d3d0b5ebbb
- CMMI Data Sharing Strategy
  - Health Affairs Forefront, August 21, 2024
- AHRQ NOFO - Accelerate Implementation of Patient-Centered Outcome Research Evidence into Practice
  - Support states in establishing Cooperatives to promote/advance dissemination and implementation patient-centered outcomes research

State Updates

- HCPF Annual Stakeholder Webinar
  - Held August 27, 2024
  - Materials: https://hcpf.colorado.gov/events/2024-stakeholder-webinar
- Making Care Primary
  - Payer sessions – ongoing
  - Learning design sessions – ongoing

Review of Aligned APM Parameters

§10-16-157, C.R.S. and Regulation 4-2-96

- §10-16-157(3)(a)(I), C.R.S. – The Division shall develop alternative payment model parameters by rule for primary care services offered through health benefit plans.
- 4-2-96 – Concerning Primary Care Alternative Payment Models
  - Risk adjustment
  - Patient attribution
  - Aligned core competencies
  - Aligned quality measure sets

§10-16-150, C.R.S.

- §10-16-150(1), C.R.S. – The commissioner shall convene a primary care payment reform collaborative to:
  - (j) Annually review the alternative payment models developed by the Division pursuant to section 10-16-157(3) and provide the Division with recommendations on the models.

- §10-16-150(2.5), C.R.S. – In carrying out the duties of subsection (1)(j) of this section, in addition to the members of the Collaborative described in subsection (2) of this section, the Commissioner shall include health insurers and health-care providers engaged in a range of alternative payment models.

Timeline

*** TBD ***

- PCPRC, payers, providers on annual basis

Stakeholder Engagement

Regulatory Updates

- Rulemaking process
- Rule adoption

3-4 months (draft to effective)

CALENDAR YEAR (1/1)

- Effective in provider APM contracts

Contract Requirements

Dec 2023 -> 1/1/25

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Massachusetts

Quality Measure Alignment Taskforce

In 2017, the Executive Office of Health and Human Services (EOHHS) established the Quality Measurement Taskforce to:

- Build **consensus on an aligned measure set** for **voluntary adoption** by private and public payers and by providers in global budget-based risk contracts
- Identify strategic **priority areas for measure development** where **measure gaps** exist
- Advise on the **measurement and reporting of health and health care inequities** and **accountability** for reducing such inequities

Measure Set Development

- Measures determined by Taskforce members with guiding criteria
- Feedback from multiple stakeholder groups and public comment
- Refreshed yearly for contract implementation

See more: EOHHS Quality Measure Alignment Taskforce | Mass.gov

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Measure Set Development

The **Core Set** includes measures that payers and providers are expected to always use in their global budget-based risk contracts…

1. CG-CAHPS2 (MHQP3 version)
2. Childhood Immunization Status (Combo 10)
3. Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: HbA1c Poor Control (>9.0%)
4. Controlling High Blood Pressure
5. Screening for Clinical Depression and Follow-Up Plan (CMS or MassHealth-modified CMS)
6. Substance Use Assessment in Primary Care

… and 24 measure in a **Menu Set** that includes all other measures from which payers and providers may choose to supplement the Core measures.

The Taskforce also develops a **Monitoring Set**, **On Deck Set**, **Developmental Set,** and **Innovation Set** for tracking. Definitions are available in the appendix.

See more: 2024 Quality Measures

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Measure Set Definitions

- **Monitoring set** includes priority areas of interest, but because recent health plan performance has been high, or data are not currently available, were not endorsed for Core or Menu Set use.
- **On Deck Set** includes measure(s) that the Taskforce has endorsed for the Core or Menu Set and which the Taskforce will move into those sets in the two or three years following endorsement to give providers time to prepare for reporting
- **Developmental Set** includes measures with defined specifications that have been validated, tested, and/or are in use in other states that the Taskforce has elected to track
- **Innovation Measure Set** includes measures which address a) clinical topics or clinical outcomes in the Core or Menu Sets utilizing a novel approach or b) clinical topics that are not addressed in the Core or Menu Set

Measure Set Implementation

Implementation:

For 2024 **measure set implementation,** parameters were released in June 2023 for January 2024 contract implementation:

- **Implementation parameters:** Automatic incorporation of annual measure set modifications, voluntary adoption, meaningful financial implications, measuring inequity reduction.
- **Guiding principles across measures:** Reasonable benchmarks, adequate denominators, recommending 15 or fewer measures.

Review Process:

The Taskforce conducts an annual review of the Massachusetts Aligned Measure Set and finalizes any **recommended modifications to the measure set by 5/31 each year for the next calendar year**.

See more: 2024 Implementation Parameters

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Measure Set Uptake and Monitoring

- Measures sets are publicly released to allow for contract implementation timeframes. Although update is voluntary, **uptake on core and menu set has been very strong:**
  - Adherence to the Aligned Measure set among those insurers that report to the Task Forces has steadily increased **from 65% in 2019 to 93% for 2023.**
  - Task Force is in the process of planning an impact analysis to understand how this alignment work has impacted provider burden and other outcomes.

Enabling Consensus & Payer Collaboration:

- Inviting a broad range of stakeholders to have a seat at the Task Force and reprocuring members every 3 years has contributed positively for a broad range of perspectives.
- Task Force is chaired by the Undersecretary for Health, and Aligned Set is approved by the Secretary to underscore importance.

See more: Measure Set Dashboard

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Rhode Island

Rhode Island – Aligned Quality Measures

- Initial measure alignment started under RI State Innovation Model (SIM) in 2015
- Measure Alignment function transitioned to Office of Health Insurance Commissioner (OHIC)
  - Statutory change requiring all commercial payers use Aligned Measure Sets in any contract with financial incentive tied to quality
  - OHIC is responsible for convening the work group annually to review quality measures and make changes to the Aligned Measure Sets as necessary
- Annual Review Committee process
  - Convened by August 1, and completed on or after October 1
  - Effective for insurer contracts with performance periods beginning on or after the 1st of January following the Annual Review Meeting(s)

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Washington State

Washington State – Aligned Quality Measures

- Primary Care Transformation Initiative
  - Goal: systemwide alignment in support of primary care across payment models, practice supports, quality standards, operational considerations
  - Accountability framework comprised of transformation and clinical quality metrics tied to 10 core accountabilities
- Aligned measure set
  - Payers to make good faith efforts to include Washington Primary Care Core Measure Set in APMs offered to PCTI participating practices when appropriate
  - List reviewed/revised for maximum alignment across different payer and purchaser initiatives, including Making Care Primary, through an HCA-facilitated committee
- Care delivery transformation
  - Primary Care Practice Recognition (PCPR) program - a process to evaluate provider capabilities; providers are assigned a level rating from 1 to 3

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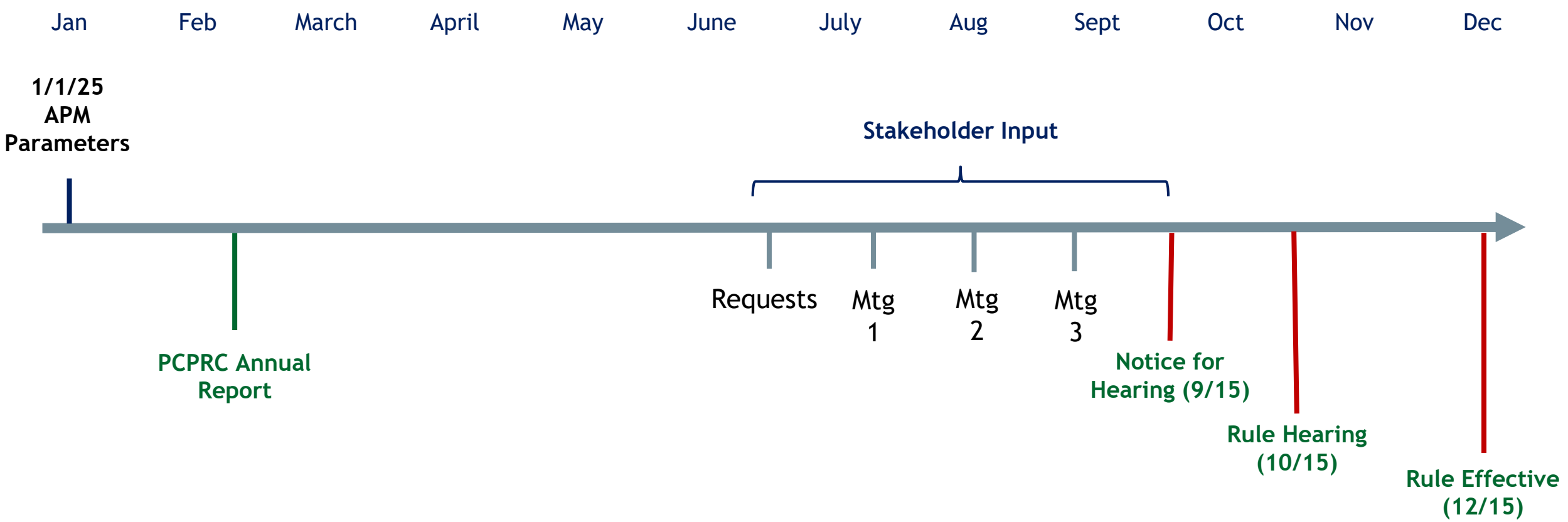
Discussion Questions

- What is the right process?
  - Mechanisms of engagement
  - Stakeholders
- What is the right timing?
  - When?
  - Number/time/format of meetings
- What resources are needed?

Timeline – Potential Option



Risk Adjustment

Use in APMs:

- Detailed description of risk adjustment methodology(ies) to participating providers
  - Definitions of key terms
  - Data used in methodology – morbidity assumptions, services included
  - Data adjustments- historical, trends, patient mix (across providers)
- Description of how risk adjustment methodology interacts with provider payments
  - Retrospective uses of provider data
  - Reconciliation processes

Reporting:

- Attestation of compliance with risk adjustment requirements
- Current or planned approach to incorporate social risk into carrier's risk adjustment methodology(ies), including but not limited to social factors such as housing instability, behavioral health issues, disability, and neighborhood-level stressors
  - Should include a statement regarding how health equity and patients with health-related social needs, and/or severe or complex health needs are or will be considered in the design of the risk adjustment methodology and the APM

Patient Attribution

Use in APMs:

- Detailed description of patient attribution methodology(ies) to participating providers
  - Definitions of key terms
  - Process(es) to attribute adult and pediatric members
- Updated attribution lists available no less than quarterly in format easy to interpret and analyze
- Maintain and establish process for reattribution
  - Process for submitting requests
  - Review process, no less than quarterly

Reporting:

- Attestation of compliance with risk adjustment requirements
- Carrier's efforts to educate members about patient attribution and/or the importance of selecting a primary care provider

Aligned Core Competencies

Use in APMs:

- Core competencies (Appendix B) must be incorporated into care delivery expectations
  - Carriers must provide simple attestation form for providers to identify Track (1,2,3)
  - Participation in certain initiatives or designations automatically qualify as Track 1
- Payments to support, incentivize, or reward provider performance of competencies must be meaningful
- Other care delivery expectations may be included at mutual agreement of carrier and provider

Reporting:

- Attestation of compliance with risk adjustment requirements
- A complete list of any additional care delivery expectation, outside of the core competencies in Appendix B, included in the carrier's APMs for primary care services

Aligned Quality Measures

Use in APMs:

- Aligned measures must be included in a quality measure set for primary care APMs
  - Impact payment in meaningful way
  - Measure specifications must be followed
  - Adult/pediatric based on practice's panel composition
- May include measures in addition to aligned measure sets
- May petition Commissioner to modify or waive certain requirements
- Aligned measures reviewed annually

Reporting:

- Included in annual APM Implementation Plan (required by Regulation 4-2-72)
  - Updated guidance forthcoming
- Complete list of measures outside of aligned measure sets included in primary care APMs
- Brief description of any requested/approved deviations or exceptions

Aligned Quality Measures

Adult Primary Care Measures

Measure	CBE
Breast Cancer Screening	2372 / NCQA
Cervical Cancer Screening	0032 / NCQA
Colorectal Cancer Screening	0034 / NCQA
Screening for Depression and Follow-up	0418 / CMS
Comprehensive Diabetes Care: HbA1c Poor Control (>9%)	0059 / NCQA
Controlling High Blood Pressure	0018 / NCQA
Consumer Assessment of Health Care Providers and Systems (CAHPS) Health Plan Adult Survey	0006 / AHRQ
Person-Centered Primary Care Measure (PRO-PM)	3568 / American Board of Family Medicine

Pediatric Primary Care Measures

Measure	CBE
Child and Adolescent Well-Care Visits	1516 / NCQA
Developmental Screening in the First Three Years of Life	1448 / OHSU
Well-Child Visits in the First 30 Months of life	1392 / NCQA
Screening for Depression and Follow-up	0418 / CMS
Childhood Immunization Status – Combo 10	0038 / NCQA
Immunizations for Adolescents – Combo 2	1407 / NCQA
Consumer Assessment of Health Care Providers and Systems (CAHPS) Health Plan Adult Survey	0006 / AHRQ
Person-Centered Primary Care Measure (PRO-PM)	3568 / American Board of Family Medicine

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Centering Equity

Step-by-Step Approach to Centering Equity

Building a Foundation

- Participants recognize disparities, develop shared understanding, and begin to work together

Focusing on Equity

- Participants coordinate targeted actions to reduce disparities and improve health equity

Advancing Equity

- Participants collaborate through shared plans to eliminated disparities and achieve health equity

Discussion Questions

- Do you still support a step-by-step approach to health equity, or should this frame/framework be revised?
  - If so, where are we in the process, and what are next steps?
  - If not, how would you like to proceed?
- Follow-up activities around Step 1?
  - Roles & responsibilities
  - Data collection
  - Summary of activities to date (follow-up reports, HB22-1325)
- What would be included in Step 2?
- Specific questions for: CMMI, other states, payers?

Themes from April Discussion

- What is updated guidance/literature on health equity
  - Looking at model outcomes
- Accountability and infrastructure are key in advancing equity
  - How can we ensure building in teeth, and not just paying lip service?
- Data collection – who, what, when, where, how, and why?
- Culturally responsiveness and humility; cultural concordance
  - Role of payment in supporting a culturally responsive workforce: types of providers included; how team-based care can reduce workforce entry barriers; how payment models can reflect training and learning goals
- Elevating voice of individuals and families
  - Meeting people where they are

Making Care Primary

Model Design Components

- Social risk and enhanced service payments (ESP)
  - Risk-adjusted non-visit based PBPM; financially support practices for caring for complex populations
- Health equity strategic plan
  - Plan to identify and close health disparities, annual reporting on goals
- Health related social needs screening & referral
  - Requires screening and referral; for advanced practices, performance assessed as part of bonus payment
- Demographic data collection

Hits and Misses

- ESP counters financial disincentives to care for patients with complex social needs
- Strategic plan and HRSN screening & referral will formalize processes for reducing disparities, connecting patients to resources
- Demographic data will enable measurement of baseline disparities and incremental progress

Potential Strategies

- No payments or penalties tied to performance on improving health outcomes for historically marginalized populations
- No plans to tie quality performance for specifical populations to payment
  - Financial incentives designed to improve quality for all patients (equality not equity)
  - No rewards or penalties based on progress toward equity goals in strategic plan

Source: Making Equity Primary in the Making Care Primary Model – Health Affairs (August 2023)

CMMI Implicit Bias

Kidney Care Choices

- Black Americans more than 3 times as likely to have end-stage renal disease (ESRD)
- Care coordination and payment incentives for providers serving beneficiaries with chronic kidney disease, ESRD
  - Beneficiary alignment with model determined in part by eGFR
- Race-adjustment of eGRF standard screening practice at time, but has since been found to artificially elevate kidney function in Blacks
  - Leads to delayed referrals to specialists and transplant listings and worse health outcomes

Comprehensive Care for Joint Replacement

- Black Americans more likely to experience arthritis-related work limitations/severe pain, less likely to receive joint replacements
- Bundled payments for lower extremity joint replacements improve care quality, reduce spending
- CJR target price based on blend of hospital's historical spending and regional averages, initially not adjusted for socio-demographic factors
  - Black and low-income patients receive fewer offers of replacement
  - Beneficiaries less medically complex, less likely to be dual eligibles

Million Hearts Cardiovascular Risk Reduction

- Blacks more likely to experience heart failure, stroke, peripheral vascular disease, at an earlier age
- Black and Hispanic adults more likely than Asian or White to be obese and have diabetes
- ASCVD Risk Calculator required to determine eligibility to receive targeted interventions
- ASCVD developed specifically for Black and White populations; anyone else identified as "Other"
  - Systematic underestimation of 10-year ASCVD score for certain racial/ethnic groups and people with low SES

Source: CMS Innovation Center Tackles Implicit Bias– Health Affairs (July 2022)

Discussion Questions & Next Steps

- Key concepts: accountability & infrastructure
- Culturally responsive care & cultural concordance
- Data

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Colorado Marketplace

Centering Question

- Are the payments that we are putting forth by changing payment structures getting to the right places?
  - PE entities capitalizing on opportunity to make money off payment changes
  - Our goal: payments to strengthen primary care delivery and workforce
  - Is that happening, and if not, how do we get in front of that?

Today's Question

- How do market dynamics in Colorado impact flow of primary care dollars?

PAYERS

- Private Insurance
- Medicaid - HCPF
- Medicare

- CMMI Models
- ACOs
- Network Arrangements

PROVIDERS

- Integrated Delivery Systems
- Safety net providers
- Practice size
- Geography (urban, rural)

Centering Question

- Are the payments that we are putting forth by changing payment structures getting to the right places?
  - ACO structures
  - Independent rural providers
  - Other

Draft Schedule

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Public Comment

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Thank you!!