Agenda

• Introduction of Alternative Payment Models (APMs) and the value it offers to health care.
• Brief discussion regarding data intake, challenges, trends and summary of total medical spending for APMs
• Overview of the Primary Care Collaborative, recent legislation passed, and an overview of Medicaid’s role in relation to primary care APMs
• Questions/Feedback from Participants
• **Housekeeping:** Session is being recorded, questions via the chat box
Presenters

David M. Keller, MD
University of Colorado School of Medicine and Children's Hospital of Colorado, Professor and Vice Chair

Maria de Jesus Diaz-Perez, PhD
CIVHC, Director of Research and Performance Measurement

Tara Smith
Colorado Division of Insurance, Primary Care and Affordability Director

Chris Kennedy,
District 23, Colorado State Representative

Trevor Abeyta, Colorado Department of Health Care Policy and Financing, Payment Reform Section Manager
Our Mission

We strive to empower individuals, communities, and organizations through collaborative support services and health care information to advance the Triple Aim: Better Health, Better Care, Lower Cost

We are:

• Non-profit
• Independent
• Objective
Who We Serve

Change Agents

Individuals, communities, or organizations working to lower costs, improve care, and make Colorado healthier.
What’s in the CO APCD?

- 870+ Million Claims
- 36 Commercial Payers, + Medicaid & Medicare
- 5+ Million Lives
- Nearly 70% of Insured (medical only)
- 2013-Present
How We Inform

Public CO APCD Data
Identify opportunities for improvement and to advance health care through public reports and publications

Non-Public CO APCD Data
Datasets and reports to address specific project needs aimed at better health, better care and lower costs
ALTERNATIVE PAYMENT MODELS: PAYING FOR VALUE, NOT JUST FOR VOLUME

David Keller MD, FAAP
Professor and Vice Chair of Pediatrics
University of Colorado School of Medicine and Childrens Hospital Colorado
Idea: Changes in payment will drive changes in practice

- We need to pay for value, not just for volume

- “If you are going to regulate something complicated, you need lots of dials”
  - Paul Grundy, MD

- Value-based payment models are the dials!
Defining Value-Based Payments using HCP-LAN Alternative Payment Model Framework

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
<th>Category 4</th>
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<tbody>
<tr>
<td>Fee for Service – No Link to Quality &amp; Value</td>
<td>Fee for Service – Link to Quality &amp; Value</td>
<td>APMs Built on Fee-for-Service Architecture</td>
<td>Population-Based Payment</td>
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<td>Foundational Payments for Infrastructure &amp; Operations</td>
<td>APMs with Upside Gainsharing</td>
<td>Condition-Specific Population-Based Payment</td>
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<td>Pay for Reporting</td>
<td>APMs with Upside Gainsharing/Downside Risk</td>
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<td>Rewards for Performance</td>
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<td>Rewards and Penalties for Performance</td>
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https://hcp-lan.org/groups/apm-fpt/apm-framework/
Category 1: Fee for service

Process
• Provider performs service
• Provider codes service
• Provider bills patient (insurance)
• Patient pays co-pay (or percentage)
• Insurance pays based on code

KEY TO SUCCESS:
Coding
Volume
Category 2: Fee for service, Link to Quality and Value

- **Process**
  - Provider performs service
  - Provider codes service
  - Provider bills patient (insurance)
  - Patient pays co-pay (or percentage)
  - Insurance pays based on code and on performance on quality and value metrics

**KEY TO SUCCESS:**

- Coding
- Volume
- **Understanding and implementing QI processes**
Category 3: APMs Built on Fee for Service Architecture

- Process
  - Payer defines a covered population
  - Provider performs service
  - Provider codes service
  - Provider bills patient (insurance)
  - Patient pays co-pay (or percentage)
  - Insurance pays based on code and on performance on quality/value metrics
  - Insurance and provider share in savings (and possibly losses)

**KEY TO SUCCESS:**

- Coding
- Volume
- Understanding and implementing QI processes
- Managing population health
Category 4: Population-based Payment

- **Process**
  - Payer defines a covered population
  - Insurance negotiated comprehensive payment to handle
  - Provider(s) provides services
  - Providers savings (and possibly losses)

**KEY TO SUCCESS:**
- Coding
- Volume
- Understanding and implementing QI processes
- Managing population health
- Managing risk
As always:

The Devil is in the Details

<table>
<thead>
<tr>
<th>Payment Model</th>
<th>Pitfalls in Operationalizing</th>
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<tbody>
<tr>
<td>FFS</td>
<td>• Fee schedule favors procedural over cognitive care&lt;br&gt;• Overall inadequate primary care reimbursement</td>
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<tr>
<td>Traditional Capitation</td>
<td>• Lack of adequate risk adjustment for patient needs&lt;br&gt;• Basing rates in historic inadequate FFS payments</td>
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<tr>
<td>Pay for Performance</td>
<td>• Measures largely disease-focused, often process rather than outcomes, not patient-oriented or reflective of key components of primary care&lt;br&gt;• Delays in receiving incentives</td>
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<tr>
<td>Shared Savings/ACOs</td>
<td>• Providers still paid FFS&lt;br&gt;• Basing benchmarks on historic expenditures rewards prior inefficiency&lt;br&gt;• Lag in receiving savings</td>
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<tr>
<td>Blended FFS and Capitation</td>
<td>• Predominance of FFS over PMPMs may not reach a tipping point that enables restructuring practice</td>
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Stephanie Gold, Presentation to the PCPRC, 2019
What about children?: Don’t really fit the model

- 24% of population
  - Less chronic disease
  - Great impact of social conditions
- Important outcomes are harder to measure
  - Take longer
  - Cross systems
- 11% of total spend
- Savings may not be enough to fund transformation

Total Health Spend, 2018, $3.6T
CIVHC APM Collection and Analysis

• Maria de Jesus Diaz-Perez, Director of Research and Performance Measurement
Background

• In 2019, CIVHC began collecting APM information from health insurance payers for the first time through Data Submission Guide rule change.
  • House Bill 19-1233 passed the same year - Concerning payment system reforms to reduce health care costs by increasing utilization of primary care

Data Sources:

1. Payer-submitted APM files
   • CIVHC receives APM submission from 13 payers.
     • Each payer submits a test file in July and submits a production file in September
     • CIVHC validates the test files and shares the findings to the payer

2. Claims from the CO APCD
   • For FFS-only payers, primary care and total medical spending data is sourced from the CO APCD.
# Background: Alternative Payment Model Data Collection Timeline and Challenges

<table>
<thead>
<tr>
<th>Year</th>
<th>Events</th>
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| 2019 | • Produced claims-based Primary Care report, based on methodology used by Balit, Friedberg and Houy (2017).  
• Adopted Oregon Health Authority APM classification  
• Initial APM data collection |
| 2020 | • The Collaborative issued first set of recommendations:  
  • CIVHC implemented Primary Care definition  
  • HCP LAN categorization for APM collection  
  • Technical modifications to APM data collection:  
    • Colorado resident vs. contract situs  
    • Added Line of Business detail  
| 2021 | • Changes to APM data collection:  
  • Added fields to identify prospective/retrospective payments  
  • Qualitative Supplement to APMs submission  
  • Improved APM data collection and validation process by increasing engagement with carriers’ data and policy teams  
  • Attestation requirement |
Background: APM Data Collection and Validation Process

1. APM test file carrier submission
2. CIVHC Validation and Findings Submission to carrier
3. Meeting with carriers (data and policy team), review validation results and contract supplement
4. APM file resubmission
5. APM file validation and attestation
Challenges and Lessons Learned

• Define denominator
  • Including pharmacy, dental or vision services
• Implications of primary care definition
• Need of continued conversations with carriers
  • Building connections and relationships between data and program/policy teams within carriers
• Plans identify primary care providers differently than the definition recommended by the Collaborative and used by CIVHC
  • Using a state health care workforce data directory as an external validation
• Medicaid puzzle
  • Working more closely with the State Medicaid agency to ensure that payments associated with ACCs are properly represented
Trends and summary of total medical spending for APMs % of Total Medical Spending

Total APM Payments vs. Percent of APMs Across All Medical Payments 2018-2020

(Integrated Payer-Provider Systems Not Included)
Trends and summary of total medical spending for APMs % of Total Medical Spending

Total Payments vs. Total APM Payments
Commercial Payers, 2020

ALTERNATIVE PAYMENT MODELS SUMMARY

Total All Payments vs. APM All Payments

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>Total Payments</td>
<td>$4,422,832,800</td>
</tr>
<tr>
<td>APM Payments</td>
<td>$493,362,200</td>
</tr>
</tbody>
</table>

Percent APMs of Total Payments: 11%
Trends and summary of total medical spending for APMs % of Total Medical Spending by LAN Categories

### Total APM Payments by LAN Categories Across All Medical Payments for All Payers, 2020

<table>
<thead>
<tr>
<th>Total APM Payments</th>
<th>% of APM Payments</th>
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<tbody>
<tr>
<td>Foundational Payments for Infrastructure &amp; Operations (2A)</td>
<td>$82,361,700</td>
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<tr>
<td>Pay for Reporting (2B)</td>
<td>$0</td>
</tr>
<tr>
<td>Pay for Performance (2C)</td>
<td>$1,779,394,000</td>
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<tr>
<td>Shared Savings with Upside Risk Only (3A)</td>
<td>$379,406,500</td>
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<tr>
<td>Shared Savings with Downside Risk (3B)</td>
<td>$30,147,600</td>
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<tr>
<td>Risk-Based Payments NOT Linked to Quality (3N)</td>
<td>$155,058,400</td>
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<tr>
<td>Condition-Specific Population-Based Payments (4A)</td>
<td>$133,508,700</td>
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<tr>
<td>Comprehensive Population-Based Payment (4B)</td>
<td>$947,000</td>
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<tr>
<td>Integrated Finance &amp; Delivery System (4C)</td>
<td>$0</td>
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<tr>
<td>Capitated Payments NOT Linked to Quality (4N)</td>
<td>$356,894,000</td>
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*The payments categorization corresponds to the HCP Learning Action Network (LAN) framework*
Investing in Primary Care

Tara Smith, Primary Care and Affordability Director
Colorado Division of Insurance
Concerning payment system reforms to reduce health care costs by increasing utilization of primary care

Primary Care Payment Reform Collaborative

Affordability Standards
PCPRC Composition & Responsibilities

RESPONSIBILITIES

- Advise in the development of affordability standards and target investments in primary care
- Analyze the percentage of medical expenses allocated to primary care
- Develop a recommendation of a definition of primary care
- Identify barriers to the adoption of alternative payment models (APMs) by health insurers and providers
- Develop recommendations to increase the use of APMs
- Increase investment in primary care delivery without increasing total costs of care and costs to consumers
• APCD administrator shall provide an annual report to the Commissioner for use by the PCPRC regarding primary care spending by:
  ◦ Commercial carriers;
  ◦ Colorado’s Medicaid program (Health First Colorado); and
  ◦ Children’s Health Insurance Program (CHP+)

• Report must include:
  ◦ Percentage of total medical expenditures allocated to primary care;
  ◦ Share of payments that are made through nationally recognized APMs;
  ◦ Share of payments that are not paid on a fee-for-service (FFS) or per-claim basis
PCPRC Annual Recommendation Reports

Theme 1: Investing in primary care

Theme 2: APMs and payer alignment

Theme 3: Health equity and collaboration

https://doi.colorado.gov/insurance-products/health-insurance/health-insurance-initiatives/primary-care-payment-reform
## PRPCR Recommendations

<table>
<thead>
<tr>
<th>2019</th>
<th>2020</th>
<th>2021</th>
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<tbody>
<tr>
<td>Broad and inclusive definition of primary care</td>
<td>Multi-payer alignment</td>
<td>Guiding increased investment in primary care</td>
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<tr>
<td>Primary care investment target</td>
<td>Measuring primary care capacity and performance</td>
<td>Centering health equity in APMs</td>
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<tr>
<td>Measuring the impact of primary care spending</td>
<td>Measuring system-level success</td>
<td>Integrating behavioral health in a primary care setting</td>
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<tr>
<td>Investing in advanced primary care delivery models</td>
<td>Incorporating equity into the governance of health initiatives</td>
<td>Increasing collaboration between primary care and public health</td>
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<tr>
<td>Investing in infrastructure and through APMs</td>
<td>Data collection to address health equity</td>
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</tbody>
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Primary Care Expenditures - APCD Reporting

- HCP LAN categorization for APM collection
- Broken out by line of business
- Added fields to identify prospective payments

- Family medicine physicians in an outpatient setting and when practicing general primary care
- General pediatric physicians and adolescent medicine physicians in an outpatient setting and when practicing general primary care
- Geriatric medicine physicians in an outpatient setting when practicing general primary care
- Internal medicine physicians in an outpatient setting and when practicing general primary care (excludes internists who specialize in areas such as cardiology, oncology, and other common internal medicine specialties beyond the scope of general primary care)
- OB-GYN physicians in an outpatient setting and when practicing general primary care
- Providers such as nurse practitioners and physicians’ assistants in an outpatient setting and when practicing general primary care
- Behavioral health providers, including psychiatrists, providing mental health and substance use disorder services when integrated into a primary care setting
**Requirement:**

- One percentage point increase in 2022 and 2023

**Target:**

- 25% primary care expenditures through prospective payments by end of CY 2023

**APM Expenditures**

**Target:**

- 50% of total medical expenditures in APMs by end of 2022
- 10% of APM expenditures through prospective payments by end of CY 2023
### Primary Care Aligned APM

- Primary care provider types
- Adoption of advanced primary care delivery competencies
- Aligned quality measures
- Support to primary care practices to facilitate transition to APMs
- Advanced APM considerations
  - Services included in APMs
  - Shared savings models for children’s care
  - Patient attribution
  - Risk adjustment
  - Prospective payments
- Monitoring APMs for unintended consequences

### Maternity Care Aligned APM

- Episode definition
  - Timing
  - Patient population
  - Services
- Accountable entity
- Aligned quality measures
- Risk adjustment
- Patient attribution
- Provider/practice support
State Transformation Collaboratives (STCs)

The STCs offer a new approach to VBC models and APM design.

Objective:
Shift the economic drivers away from fee-for-service to a person-centered approach to health through alignment among Medicare, Medicare Advantage, Medicaid, and commercial payers and purchasers in selected states.

Key Components:
- 4 distinct state collaboratives
- Comprised of payers, providers, health systems, purchasers, patient advocates, and community organizations
- Locally-focused approach that features state level Medicare and Medicaid alignment
- Prioritizes states with greatest opportunity to impact health equity

Potential Goals:
- Shift 60% of payments to an APM for participating providers in a state
- Avoidable hospitalizations
- 2 to 3 state-specific goals tailored to local needs

January 2022:
Draft state roadmap and meet with STC leadership

January-February 2022:
Host a Design Session for each STC and hold additional stakeholder discussions

Spring 2022 Onward:
Hold regular meetings with STCs and measure progress

The STCs offer a new approach to VBC models and APM design.
Looking ahead

July 2019
PCPRC convened

Dec 2019
1st Annual Report

Dec 2020
2nd Annual Report

Dec 2021
3rd Annual Report

Feb 2022
4th Annual Report

Feb 2023
5th Annual Report

Feb 2024
6th Annual Report

Sep 2025
PCPRC sunset

HB19-1233

Regulation 4-2-72

HB22-1325

APM parameters regulation

Aligned APM parameters implementation

1% increase in PC spending

APM Alignment Initiative

(TBD)

State Transformation Collaborative
THANK YOU
Why was additional legislation needed?

- Limited cooperation from health insurance carriers
- Fear among providers of under reimbursement, perverse incentives, and unintended consequences
- Increased focus on systems that advance equitable outcomes
Establishes a process that includes the Division of Insurance, the Department of Health Care Policy & Financing (Medicaid), and the Department of Personnel & Administration (State Employee Plans)

Sets clear goals for what APMs are to achieve, including:

- Increased primary care investment & better healthcare system value
- Improved access and more equitable outcomes
- Integration of behavioral health care
Directs the Division of Insurance to establish aligned APM parameters, including:
- Quality Metrics
- Risk Adjustment
- Attribution Methodologies
- Core Competencies
Requires state-regulated insurance companies to incorporate these parameters into their APMs for plans issues on or after January 1, 2025
Requires data collection & analysis

House Bill 1325
HCPF Primary Care Payment Reform

Presented by Trevor Abeyta
Payment Reform Section Manager, HCPF
Goals of Medicaid Primary Care Payment Reform

- Improve Outcomes & Patient Experience
- Close Health Disparities
- Support Primary Care Providers
- Improve Affordability
Primary Care Transformation Timeline

- APM 1: 2018
- APM 2 (Non-FQ + FQHC): 2022
- APM 2 (Pediatrics): 2023
- APM 2: Cover all Medicaid Members: 2025
Supporting Primary Care Providers w/ Data

Medicaid Claims Data → Medicaid Value Based Payments Analytics System → Provider Portal & EHR System → Actionable Insights to Manage Members Health

EHR Data
Closing Health Disparities

- Stratify Quality Performance
- Identify Disparities
- Share Data
- Tie Improvement to Payment
Multi-Payer Alignment

HCPF APM Strategy: Align Across Payers Wherever Possible

Bailit Health Workgroups  State Transformation Collaborative  HB22-1325
Questions and Feedback

Reach out to info@civhc.org

Connect with CIVHC on Facebook, LinkedIn, and Twitter

Recording will be posted here: www.civhc.org/about-civhc/news-and-events/event-resources/