AGENDA
Primary Care Alternative Payment Methodology (APM)
Track 2 Work Group
Department of Health Care Policy and Financing

303 East 17th Avenue 11th Floor Conference Room 11A
Denver, CO 80203

February 16th, 2017
3:00 P.M.

1. Welcome and Introductions

2. Introductory Remarks and Meeting Purpose

Work Group Purpose: work through the operational detail needed to implement primary care capitation models similar to those proposed by Medicare in the CPC+ initiative under the Track 2 payment.

Meeting Purpose: discussion of possible track 2 payment model designs for HealthFirst Colorado’s PCMPs.

Meeting Product: proposals and ideas for track 2 payment model designs.

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.

3. APM 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, including social determinants of health.
• Create flexibility to allow for changes in business practices and increased efficiencies.

• Have a realistic timeline for practice transformation with input from stakeholders.

• 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 from the Department.

• Ensure regional and practice differences are addressed and that reforms work for all of Colorado

A. Measurement Principles

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

4. Quick review of lessons learned to-date

5. 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 particular focus on patients with complex needs.

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

   - 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 1?

   - Accountability mechanisms
     - Utilization rates
     - Quality targets
     - Required reporting

   - Payment reconciliation
   - Attribution
   - Quality incentives

7. **Adjourn**
Reasonable accommodations will be provided upon request for persons with disabilities. Please notify the Board Coordinator at 303-866-3967 or timothy.bergman@hcpf.state.co.us or the 504/ADA Coordinator hcpf504ada@state.co.us at least one week prior to the meeting to make arrangements.