Colorado Alternative Payment Model (APM) Alignment Initiative

Final Report

June 2022

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Introduction

As a state, Colorado has long focused on improving its health care system by ensuring access to high-quality, affordable health care for Coloradans. In furtherance of its ongoing efforts, in the spring of 2021, Colorado initiated a process to develop a multi-payer statewide alternative payment model (APM), with the goal of aligning payers' efforts to shift away from fee-for-service (FFS) payments to value-based payments. As defined in Department of Insurance (DOI), Regulation 4-2-72, "Concerning Strategies To Enhance Health Insurance Affordability," an APM is a health care payment method that uses financial incentives to promote greater value – including higher quality care at lower costs – for patients, purchasers, and providers.

A statewide aligned health care APM is intended to reduce administrative burden for providers, increase health care value, and improve quality and health equity for consumers. This aligned APM effort leverages and builds off of previous and continuing efforts in the state to encourage APM usage as a means to improve the overall delivery of care, such as the Colorado State Innovation Model (SIM) award, its participation in the federal Comprehensive Primary Care Plus (CPC+) initiative, and the ongoing work of the Primary Care Payment Reform Collaborative.

In order to achieve these goals, the Office of Saving People Money on Health Care in the Lieutenant Governor's Office partnered with the Department of Health Care Policy and Financing (HCPF), the Division of Insurance (DOI), and the Department of Personnel and Administration (DPA) to develop a multi-stakeholder process to align APMs. Bailit Health was engaged to support these collaborative efforts, and began by interviewing stakeholders to understand broader interests in and barriers to pursuing a statewide APM. This work informed the establishment and convening of an overarching APM Alignment Advisory Group and two Sub-Groups focused on primary care and maternity care. The goal of these multi-stakeholder groups was to develop recommendations on Colorado-specific, consensus-based APMs that could be used to advance alignment of value-based payment approaches within the public and commercial markets.

This document summarizes findings and recommendations from Bailit Health's work.

Stakeholder Interviews

Bailit Health conducted 24 stakeholder interviews between April and May of 2021 to lay the groundwork for beginning a work group process by identifying: (a) existing APMs in the markets, (b) will and interest among stakeholders to pursue a statewide APM, and (c) challenges to participation and other barriers to a statewide APM in Colorado.

Due to COVID-19 restrictions, Bailit Health conducted one-hour interviews virtually with representatives from HCPF, DOI and DPA, providers, health plans with lines of business in Colorado, Colorado purchasing alliances, and consumer advocates. Bailit Health developed and shared in advance with interviewees a semi-structured interview guide. Interview guides were not identical across stakeholders, but questions were very similar and covered the same topics.

After analyzing feedback from the stakeholder interviews, Bailit Health found that overall, there was interest in alignment of APMs in order to encourage greater adoption of APMs across the state. Additional findings include the following themes:

1. Key benefits of APMs include improving outcomes for patients and reducing provider burden.

2. Stakeholders recognize that payer alignment is complicated, particularly given that many of Colorado's health plans are national plans that want consistency across their markets and lines of business.

3. Stakeholders noted that there is some "piloting fatigue" and that it is important to consider provider readiness and technical assistance needs.

4. All stakeholders should be included in activities to develop aligned APMs, including consumer advocates, to ensure that APMs are beneficial for consumers and do not have unintended consequences.

5. The strongest potential areas for APM alignment are in primary care and maternity care.

APM Alignment Approach

The feedback from stakeholder interviews led to the establishment of three voluntary stakeholder groups – one overarching APM Alignment Advisory Group and two Sub-Groups, as described below:

1. **APM Alignment Advisory Group**, whose membership included stakeholder representatives who could provide feedback on how the technical discussions occurring in each Sub-Group fit into the broader strategies and landscape of APM work.
2. **APM Alignment Primary Care Sub-Group**, whose membership included stakeholder representatives with subject matter expertise in primary care and primary care APM design.
3. **APM Alignment Maternity Care Sub-Group**, whose membership included stakeholder representatives with subject matter expertise in maternity care and maternity care APM design.

The State invited a broad array of stakeholders to participate in the meetings and attempted to ensure that each group had sufficient multi-stakeholder representation, including State representatives, payers, providers, health plan and provider associations, purchasing alliances, and consumer advocates.[1] All meetings were virtual and open to the public, and the State posted all meeting registration information, along with meeting agendas, presentations, and recordings, on the APM Alignment Initiative website. Appendix A includes a membership roster that indicates participation across each stakeholder group.

APM Alignment Advisory Group

The APM Alignment Advisory Group informed Colorado's efforts to align APMs for primary care and maternity care within Health First Colorado (Colorado's Medicaid program, administered by HCPF); individual, small group, and large group plans regulated by the DOI; ERISA plans administered by commercial carriers; and the Colorado state employee self-funded health plan (administered by DPA). The APM Alignment Advisory Group met four times – approximately every two months, starting on Tuesday, August 17, 2021 and ending on Friday, April 29, 2022.

There was an overlap of participants in the Advisory Group and Sub-Groups, and regular participants of the Advisory Group consisted of representatives from state agencies, health plans, providers, health plan and provider associations, purchasing alliances, and consumer advocacy groups.

The Advisory Group reviewed and provided feedback on topics and recommendations discussed by the respective Sub-Groups, as described in the below sections, as well as health equity considerations in the design of a multi-payer APM.

[1] Colorado state staff made a concerted effort to include consumer advocates within these groups, recognizing the importance of consumer input generally and in relation to health equity specifically. We recognize that it is easier to engage those consumer stakeholders who are already known to the state.

APM Alignment Primary Care Sub- Group

The goal of the Primary Care Sub-Group was to improve the value of primary care in Colorado by making consensus-based recommendations to the state on an aligned APM approach for primary care. Early on, the Sub-Group adopted the Centers for Medicare & Medicaid Services (CMS) definition of value-based care: paying for health care services in a manner that directly links performance on cost, quality, and the patient's experience of care.[2] The Primary Care Sub-Group met nine times, starting on Monday, August 30, 2021 and ending on Friday, April 8, 2022.

Regular participants of the Primary Care Sub-Group consisted of representatives from state agencies, health plans, providers, health plan and provider associations, and consumer advocacy groups.

As discussed further below, the Primary Care Sub-Group reviewed previous and current statewide, multi-payer primary care APM efforts. The Sub-Group also discussed a number of primary care APM specific topics including: the definition of primary care, services included in primary care APMs, primary care practice supports necessary to support APM implementation, quality measures, patient attribution, risk adjustment, and prospective payments. Health equity was a primary lens through which the group approached these topics. Based on these discussions, the Sub-Group developed recommendations for a Primary Care Aligned APM. Bailit Health also regularly presented at meetings of the Primary Care Payment Reform Collaborative (PCPRC) to discuss the Sub-Group's progress and get guidance from PCPRC members to ensure that the Sub-Group appropriately leveraged the ongoing work of the Collaborative.

APM Alignment Maternity Care Sub-Group

The goal of the Maternity Care Sub-Group was to improve the value of maternal and infant health in Colorado by making consensus-based recommendations to the state on an APM for maternal and infant health. The Maternity Care Sub-Group met nine times, starting on Thursday, September 2, 2021 and ending on Tuesday, April 12, 2022.

Regular participants of the Maternity Care Sub-Group consisted of representatives from state agencies, providers, health plan and provider associations, purchasing alliances, and consumer advocacy groups. There was limited participation from health plans in this Sub-Group.

As further discussed below, the Maternity Care Sub-Group reviewed existing maternity episode designs within and outside of Colorado. The Sub-Group also discussed specific elements of an episode to design an aligned maternity episode, including the episode definition (timing, patient population, and included services), accountable entity, quality measures, risk adjustment, and patient attribution.

[2] https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/nursing/meetings/2018/nacnep-sept2018-CMS-Value-Based-Care.pdf

Primary Care Aligned APM

Principles for Primary Care APM Development

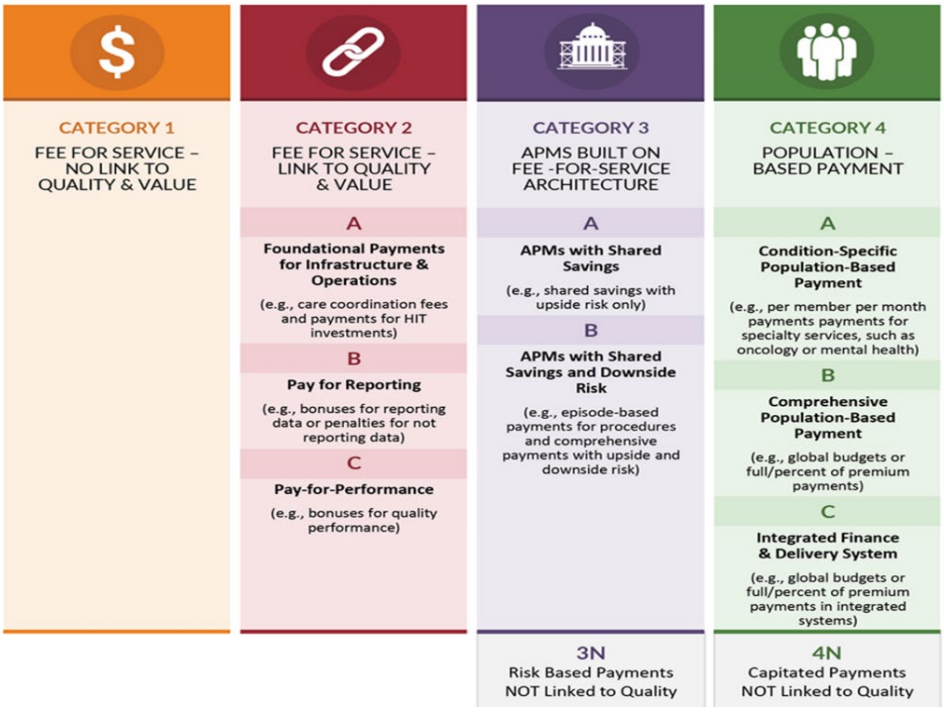
During the initial meeting of the Primary Care Sub-Group, the group agreed upon the following principles for primary care APM development, setting the stage for the group's work:

1. Leverage Colorado primary care APMs and lessons learned;
2. Learn from national primary care APM efforts;
3. Build from the recommendations of the PCPRC; and
4. Incorporate health equity into primary care APM development.

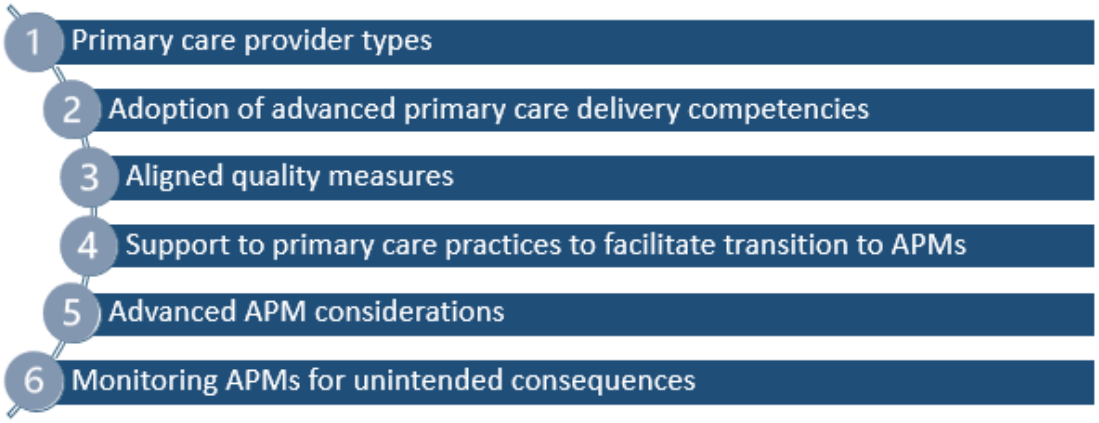
In addition to these four principles, in early discussions the group identified assumptions to frame its work, including that any primary care APMs developed through this process should:

- Meet practices where they are with APM experience and capacity to advance along the Health Care Payment Learning & Action Network (HCP-LAN) APM continuum (Figure 1);
- Allow flexibility for payers to use and build from existing APMs;
- Align where possible across public and commercial payers to maximize consistency for primary care practices; and
- Include adult and child populations. It was noted, however, that APMs for children's care may require different APM design approaches and methods than for adults.

Figure 1: HCP-LAN APM Framework



Recommended Model for Alignment



Over the course of the Primary Care Sub-Group meetings, the group reached consensus on core features of a Primary Care Aligned APM for any primary care APM. Rather than requiring a single or specific primary care APM, an "aligned" APM offers providers and payers the flexibility to implement any APM on the HCP-LAN APM continuum but with common, aligned APM parameters that include:

These common parameters are further described in subsequent sections.

Primary Care Provider Types

Primary care providers who practice general primary care in an outpatient setting, including Federally Qualified Health Centers, are eligible to participate in primary care APMs. The Sub-Group recommends including the provider types identified in Division Regulation 4-2-72, which was drawn from recommendations from the PCPRC (see Figure 2).[3]

Figure 2: Primary Care Provider Types

Primary care includes services provided by and payments to:

- 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

Adoption of Advanced Primary Care Delivery Competencies

Intentional focus on care delivery as part of APM design can promote more equitable care and support goals for reducing health disparities. The Sub-Group agreed that encouraging and incentivizing core competencies for whole-person care and structuring APM reimbursement models to help practices advance their care delivery models were important considerations for primary care APMs. Further, the group agreed on the following core competencies for whole-person care that should be incentivized in primary care APM contracts, as recommended by the PCPRC, and expanded, to include:

[3] First Annual Report of the Colorado's Primary Care Payment Reform Collaborative. December 2019. https://drive.google.com/file/d/1BINwnRr9i_TAWp3rMYZaNcR-WMCKuUyj/view

Aligned Quality Measures

A quality measurement strategy for primary care aligned across insurers, with manageable reporting requirements, helps minimize administrative burden on practices and improves the likelihood that practices will focus on highest priority quality improvement opportunities and achieve improved performance for their patients.

Central to the Sub-Group's discussion on quality measures was alignment with quality measures already in use in Colorado and the use of standardized measures derived from national quality measure sets, with particular emphasis on the CMS core quality measures, as Colorado Medicaid is required to report on these measures. To guide decisions about the inclusion of quality measures in a Primary Care Aligned APM, the Sub-Group reviewed:

- Comparable state and federal quality measure sets, including CMS' 2022 core quality measures, measures used in HCPF's primary care APM, and measures established in 2019 by Colorado's Multi-Payer Collaborative;
- Colorado's Medicaid and commercial performance on Healthcare Effectiveness Data and Information Set (HEDIS) measures relative to national benchmarks, with special attention to measures with poorer state performance; and
- Other states' aligned quality measures work and experiences.

Included in Attachment A is a complete inventory of primary care quality measures reviewed by the Sub-Group.

The Sub-Group recommends primary care APMs include quality measures from an aligned measure set for primary care, which includes both adult and pediatric measures. These measures are summarized in Figures 3 and 4 below.[4] Providers and payers should have autonomy to choose which of these measures to include in APMs and report on, depending on the populations served by the practice and practice areas of focus. For selected measures, payers should use consistent measure definitions and specifications, as identified in Attachment B, Primary Care Quality Measures Technical Specifications, to minimize the burden on providers.

The Sub-Group stressed the importance of stratifying quality measures to better understand where disparities exist. Given current challenges with data collection, the Sub-Group did not want to mandate such requirements but agreed payers should incentivize practices to stratify quality measure results by race and ethnicity. If such analyses identify disparities in health care quality or outcomes, practices and payers should collaborate to develop a quality improvement action plan that seeks to reduce identified disparities. The Sub-Group committed to ongoing learning and monitoring of national efforts to collect, assess and act on health disparities data, and to revisit these requirements in the future.

Figure 3: Adult Primary Care Measures

Domain	Measure	Number	Data Source	Steward	CMS 2022 Core
Preventive Care	Breast Cancer Screening	NQF 2372	Claims	NCQA	Yes
Preventive Care	Cervical Cancer Screening	NQF 0032	Claims/ Clinical	NCQA	Yes
Preventive Care	Colorectal Cancer Screening	NQF 0034	Claims/ Clinical	NCQA	Yes
Preventive Care	Screening for Depression and Follow-Up Plan	NQF 0418	Claims/ Clinical	CMS	Yes
Chronic Conditions	Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	NQF 0059	Claims/ Clinical	NCQA	Yes
Chronic Conditions	Controlling High Blood Pressure	NQF 0018	Clinical	NCQA	Yes
Behavioral Health	Initiation and Engagement of Substance Use Treatment	NQF 0004	Claims/ Clinical	NCQA	Yes
Patient Experience	CAHPS Health Plan Adult Survey	NQF 0006	Patient Survey	AHRQ	Yes

[4] The Primary Care Sub-Group considered a lung cancer screening measure, however, to date, no formal lung cancer screening quality indicators have been developed. Providers and payers are encouraged to monitor new work underway to develop nationally recognized lung cancer screening measures and consider their use in APMs in the future.

Figure 4: Pediatric Primary Care Measures

Domain	Measure	Number	Data Source	Steward	CMS 2022 Core
Preventive Care	Child and Adolescent Well-Care Visits	NQF 1516	Claims	NCQA	Yes
Preventive Care	Developmental Screening in the First Three Years of Life	NQF 1448	Claims/ Clinical	OHSU	Yes
Preventive Care	Well-Child Visits in the First 30 Months of Life	NQF 1392	Claims/ Clinical	NCQA	Yes
Preventive Care	Screening for Depression and Follow-Up Plan	NQF 0418	Claims/ Clinical	CMS	Yes
Preventive Care	Childhood Immunization Status	NQF 0038	Claims/ Clinical	NCQA	Yes
Preventive Care	Immunizations for Adolescents	NQF 1407	Claims/ Clinical	NCQA	Yes
Preventive Care	Lead Screening in Children	N/A	Claims/ Clinical	NCQA	No
Patient Experience	CAHPS Health Plan Child Survey	NQF 0006	Patient Survey	AHRQ	Yes

Support to Primary Care Practices to Facilitate Transition to APMs

The Sub-Group emphasized that, for many primary care practices, the level of expertise and business acumen necessary to transition to APMs and facilitate primary care transformation is not widespread. Some primary care practices may need or benefit from payer support to help them prepare for, implement, and monitor APMs. The Sub-Group highlighted the following technical assistance and education support they recommend payers offer to practices:

- **Timely, high-quality APM cost and quality performance data** in a format that can be used for comparison against budgets, benchmarks, and performance of other primary care providers in the same market/region, network, or state. Cost and quality performance data should include detailed calculations for any shared savings payments or financial liability.

- **Sessions on how APMs work**, including discussion of the financial model, such as actuarial analysis and potential for shared savings or risk, and what the provider might have to do to achieve savings or avoid risk.

- **Assistance on the use of data to manage patients**, including, for example, how to read reports, interpret data, and turn data into action.

- **An assessment of provider APM readiness**, including what providers need to be able to do to participate in a particular APM, and direct support to interested practices to assist in readiness.

Advanced APM Considerations

As primary care practices transition more payments from traditional FFS to advanced APMs, Primary Care Sub-Group members agreed there were some specific parameters important to recognize and include in the Primary Care Aligned APM: primary care services included in the APM, patients attributed to the APM, risk adjusted payments, prospective payment models and other APMs with upside/downside risk, and considerations for advanced APMs that include children's care. The Sub-Group's discussions on these topics centered on the challenges that practices face in these particular areas. As such, the recommendations included in the Primary Care Aligned APM are presented at a high level, in anticipation of future stakeholder discussions that will be informed by evolving APM standards, practices, and approaches. In addition, practices will likely need practice transformation supports and resources to facilitate the implementation of primary care APMs. These supports could include practice coaches to support modifying workflows and better use of data to manage patient care as well as infrastructure support.

Primary care services included in APMs. To minimize risk to providers and practices, when primary care APMs include shared savings/risk or capitation, services included in the APM should include primary care services only. Primary care services include services focused on prevention, health maintenance, and acute care. However, willing practices may want the option to include a broader array of services that are impacted by primary care to maximize opportunities to share in savings, such as hospital services, pharmacy, and specialty care.

Shared savings models for children's care. Sub-Group members expressed concern that models for children's care may have fewer cost saving opportunities and a longer-term return on investment than models for adults. To support practices that serve child populations, payers should consider alternatives to shared savings models, including investments to high-functioning practices through enhanced rates or performance incentives.

Patient attribution. The Sub-Group generally agreed with the HCP-LAN's recommendations for patient attribution,[5] the method used to determine which primary care practice is responsible for a patient's care and costs, with some modifications based on the group's experience.

When using patient attribution methods in Colorado primary care APMs, the Sub-Group adopts the following HCP-LAN recommendations:

- Patient attestation is the preferred method of attribution, however, when this is not available or a patient has not selected a primary care provider, the payer should use a claims/encounter-based approach.

- Payers should prioritize primary care providers in claims/encounter-based attribution.

[5] http://hcp-lan.org/workproducts/pa-whitepaper-final.pdf

- Payers, when utilizing a patient attribution methodology of their choosing, which may include attribution methodologies currently in use, should be transparent with practices about the methodology.

- Payers should provide prospective notification to practices of patients for whom they are including in APMs (at the beginning of the performance period) and reattribute patients regularly, using these updates when calculating payments, with timely communication to practices.

The HCP-LAN recommendations include steps to notify patients about their attribution and processes for changing their attribution; however, the Primary Care Sub-Group felt this burden should not fall to the patient, especially when the attribution is incorrect. The Sub-Group recommends that payers should work to reduce this burden on patients when changes to attribution or primary care physician assignment are needed.

Additionally, the Sub-Group recommends that payers and providers, together, should practice strong bilateral communications to resolve patient attribution issues and challenges. Also, the Sub-Group recognized that current attribution methods do not always translate well to pediatric-only populations, and that payers and providers should collaborate on appropriate attribution methods for APMs for children's care.

Risk adjusted payments. Risk adjustment is a method used to account for the health status of a patient population. When applied to payment, risk adjustment helps to account for underlying differences in patient populations served by different primary care practices. The goal is to reduce the incentive to seek out healthier patients and discourage sicker patients. Payment may be adjusted based on the age and sex distribution of the panel or may include more sophisticated methodologies that reflect the clinical and social profile of the patient population. The Primary Care Sub-Group recommends the following principles when using risk adjustment methods in primary care APMs:

- Payers should risk adjust payment models to account for the variation of different patient panels by health conditions, age, ***and*** gender. Members of the Sub-Group expressed interest in incorporating social risk factors into risk adjustment of payments; however, because the current methods for doing so are limited and evolving, the group committed to ongoing learning and monitoring to see how these methods evolve and mature over time. Further, the group felt it important to ensure that methods, social risk or other factors, used in risk adjustment models do not disadvantage any patient populations.

- Payers, when utilizing a risk adjustment methodology of their choosing, which may include risk adjustment methodologies currently in use, should be transparent with practices about the methodology used and how it is applied to payments.

Additionally, the Sub-Group recognized that current risk adjustment methods do not always translate well to pediatric-only populations, specifically infants and newborns, and that payers

and providers should collaborate on appropriate risk adjustment methods for APMs for children's care.

Prospective payment models and other APMs with upside/downside risk. The Sub-Group felt strongly that prospective payment models offer greater flexibility to deliver primary care that better meets the needs and preferences of patients, including an expanded care team that is more equipped to provide a whole-person care approach. While the Sub-Group considered requiring primary care practices to adopt prospective payment models, it also recognized not all primary care practices currently would be willing or have the capacity to do so. There were many limitations and concerns specific to risk and data availability discussed by the group. Primary care practices are still encouraged to move towards prospective payment over time. To minimize the risk to the practice, the Sub-Group recommends prospective payment models should only include those patients identified through an agreed upon methodology. Practices unwilling or unable to move to prospective payment are encouraged to consider APMs with upside and downside risk, including shared savings and total cost of care models.

Monitoring APMs for Unintended Consequences

With health equity top of mind, the Sub-Group emphasized the importance of monitoring APMs for unintended consequences on populations, particularly those experiencing disparities. We recommend payers use available data, such as utilization data and patient-reported measures of satisfaction, to monitor for adverse impacts such as decreasing access to services or signs of stinting on care (delivering less care than would optimally benefit the patient). Should any unintended consequences occur for those patients and populations attributed to an APM, payers should collaborate with practices to take corrective action when performance measures indicate the need to do so. Payers should share monitoring approaches and data with practices.

Recommended Future Steps

As discussed above, the Primary Care Sub-Group identified several topics and challenges with advanced APMs that require further review and assessment. These topics are described below.

In addition, a key step important to formalizing and operationalizing Primary Care Aligned APM recommendations is the establishment of a governance mechanism to ensure Primary Care Aligned APM requirements are correctly implemented and that payers comply with the requirements, once finalized and approved by the state.

HCP-LAN State Transformation Collaboratives

The CMS Innovation Center, in partnership with the HCP-LAN, selected Colorado to participate in its State Transformation Collaboratives (STC) initiative to accelerate the implementation of multi-payer APMs. Discussions and deliberations of the Primary Care Sub-Group highlighted several topics that require further exploration and consideration for inclusion in the Primary Care Aligned APM. Given their natural alignment with the STC scope, we recommend the state prioritize these topics in future STC work:

- Health equity: Continue to explore how to use primary care APMs to further health equity.
- Patient attribution: Explore best practices and approaches to improve patient attribution.
- Risk adjusted payments: Explore approaches for incorporating social risk into risk adjusted payments.
- Prospective payments: (1) Assess data challenges and explore best practices and approaches relative to data needs to support prospective payment, and (2) Develop an appropriate timeline for primary care practice transition to prospective payment models, as some Primary Care Sub-Group members thought having a vision and timeline at the state level would be helpful.
- Practice transformation supports: Identify current and promising practice transformation supports and resources to facilitate the implementation of primary care APMs.

Governance

We recommend the state establish a governance mechanism to monitor implementation of the Primary Care Aligned APM requirements, ensure payer and provider compliance (potentially through existing DOI reporting requirements), and annually review primary care quality measures to determine the need for any changes. This governance mechanism should include public and private payers, representatives from primary care organizations, consumers/consumer advocates most impacted by primary care APMs, and representatives from state agencies with aligned interests. The state may want to consider leveraging existing multi-stakeholder advisory groups, such as the PCPRC, to review and make recommendations for aligned primary care quality measures.

Maternity Care Aligned APM

Based on stakeholder interviews, which showed a focus on maternity health episodes by both the Medicaid program and commercial plans, and overall interest in focusing on areas of maternal health disparities and an imperative to improve maternal health outcomes in Colorado, developing an aligned maternity care APM was prioritized as part of the APM alignment effort.

Principles for Maternity Care APM Development

During the initial meeting of the Maternity Care Sub-Group, the group agreed upon the following principles for maternity care APM development, setting the stage for the group's work:

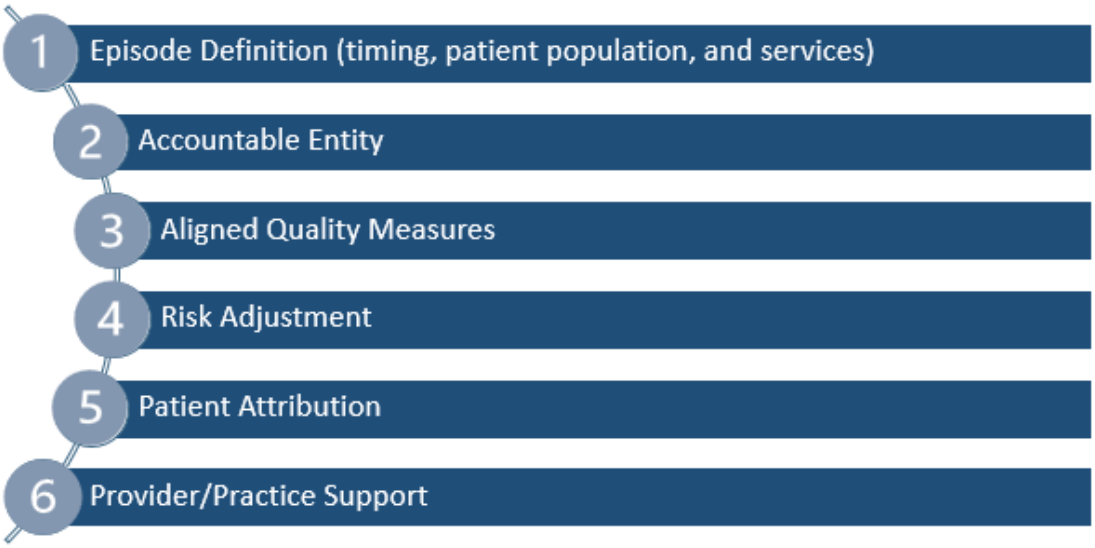
1. Incentivize person-centered care;
2. Improve patient outcomes through effective care coordination;
3. Reward high-value care;
4. Reduce unnecessary costs; and
5. Incorporate equity in decision making.

In addition to these five principles, early discussions of the group identified assumptions to frame its work, including that any maternity care APMs developed through this work should aim to:

- Increase the percentage of vaginal births and decrease unnecessary c-sections;
- Increase the percentage of births that are full-term and decrease preterm and early elective births;
- Decrease complications, morbidity, and mortality, including readmissions and neonatal intensive-care unit (NICU) use;
- Increase integration of behavioral healthcare;
- Provide support for childbearing people and their families in making critical decisions regarding the prenatal, labor and birth, and postpartum phases of maternity care and respecting those choices;
- Increase the level of coordination across providers and settings of maternity care, including community-based care; and
- Consistently provide a birthing person- and family-centered experience.

Recommended Model for Alignment

Over the course of the Maternity Care Sub-Group meetings, the group reached consensus on core features of a Maternity Care Aligned APM. These features include:



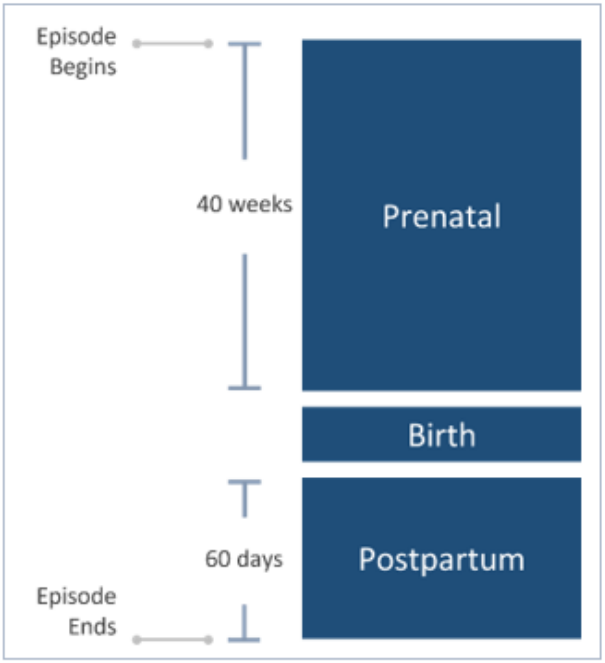
These common parameters are further described in subsequent sections.

Episode Definition (timing, patient population, and services)

Timing

Consistent with the recommendations of the HCP-LAN, the Sub-Group recommends that the episode begin 40 weeks before birth and end 60 days postpartum (see Figure 5). While some Sub-Group members expressed concern with the episode beginning at 40 weeks regardless of whether a birthing person was receiving prenatal care at that point, it is important to note that historical data used to develop the episode budget will include individuals who enter care later in their pregnancy. Including individuals beginning at 40 weeks is aimed at ensuring that individuals begin prenatal care as soon as possible. Addressing delayed maternity care is one step in addressing health disparities.

Figure 5: Episode Timing



In addition, the group discussed whether the newborn should be included in the episode and determined that this should be an optional component. If the episode's patient population

includes newborns, then the episode's end date for the newborn could be fewer than 60 days post-birth.

Nationally, most episodes include two or three of these time frames. The Sub-Group did have some discussion of the potential for allowing each portion of the episode to be considered as separate episodes, however, group consensus focused on having a combined episode which includes all part of the birthing person's experience.

Patient Population

The Sub-Group recommends that the episode's patient population should include most if not all pregnant persons to ensure a focus on health equity. At a minimum, the episode must include birthing people who exhibit low risk in addition to birthing people with elevated risk conditions who have a defined treatment plan. Inclusion of newborns in the episode should be an option for providers that choose to do so.

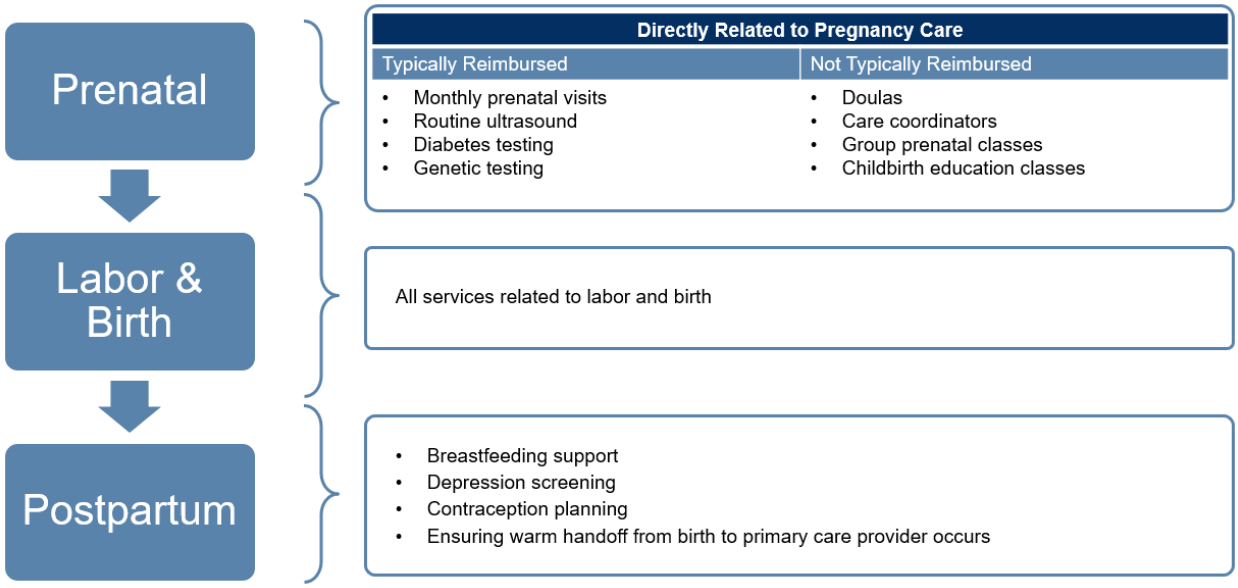
A maternity care episode should identify any exclusion criteria that would disqualify certain birthing people from the patient population of a maternity care episode. However, reasons for excluding certain birthing people from an episode should center around a payer's ability to accurately set an episode budget. While some agreements between payers and providers for episodes do not include any exclusions, others do have exclusions. For example, initiation of prenatal care in the third trimester of pregnancy may exclude birthing people from a maternity care episode because they may not be able to benefit from prenatal interventions that could affect their pregnancy outcomes. Another example of a potential exclusion criterion is exhibiting high risk for pregnancy complications, e.g., birthing people with pre-existing substance use conditions, which may incur higher and unpredictable costs. In HCPF's maternity APM, there are no condition-based exclusions, but cost outliers may be excluded.

It is important to note that appropriate payment for and the level of care delivered to these patients should not change regardless of inclusion or exclusion in a maternity care episode. Regardless of payment model, payers and providers should remain focused on improving maternity care and reducing disparities in care to improve health equity, with a particular focus on reducing maternal morbidity.

Services

The Sub-Group recommends that all services related to prenatal care, labor and birth, and postpartum care for the birthing person should be included as part of the episode (see Figure 6). This includes screening for depression, doula care, and care coordination, which are not historically reimbursed but there is movement towards coverage of these services. However, all non-pregnancy related services (e.g., a broken arm) should be excluded. If an individual has a health condition prior to pregnancy that may be exacerbated through pregnancy (e.g., an individual with high-blood pressure that is at risk for preeclampsia), that care would be considered as pregnancy-related.

Figure 6: Episode Services



As noted above, newborns may optionally be included in an episode. If newborns are included, services should be focused on initial care, but may need to exclude regular pediatric care, such as well child care visits, that is provided through pediatricians that do not participate in the episode.

Accountable Entity

Because maternity care is provided by multiple providers, the Sub-Group acknowledges that there is shared accountability across providers for the health outcomes of birthing people. Options for accountable entities who may take on financial responsibility for a maternity episode include maternity care providers (OB-GYNs, certified nurse-midwives, family physicians); birthing locations (hospitals, birthing centers, etc.), and provider organizations (ACOs, IPAs, etc.). The Sub-Group did not make a specific recommendation as to which of these providers should be the accountable entity.

Episode Payment

The Sub-Group discussed that a maternity care episode is a contract between payers and accountable entities, which should identify specific payment terms, including:

- whether payment should be made prospectively or as FFS with retrospective reconciliation (and if a retrospective reconciliation, the timing of the reconciliation)[6];
- details of financial risk arrangement, including how budget benchmarks will be developed and savings and/or losses will be calculated;
- payment schedule;
- requirements of accountable entities to distribute any portion of realized savings to individual providers or subcontracting entities;

[6] We anticipate that, to start, most models will be based on a FFS payment with a retrospective reconciliation.

- how the payment is tied to quality performance; and
- appeals process.

The contract between payers and accountable entities must include an episode budget for maternity care. An episode budget will typically be based on historical data across the different components of the episode (prenatal, delivery, postnatal, and newborn [optional]).

The Sub-Group further discussed options for setting the episode budget, including setting the budget based on the historical average of the specific provider group or on the historical average of an entire geographic area of marketplace. The former option would be relatively easy to implement and incentivize provider efficiency, but it would not eliminate historical price variation and may continue to reward high-cost, less efficient providers. The latter option may lead to reduced price variation across providers over time, but it could result in rewarding some providers and penalizing other providers, regardless of actual practice performance, especially if there is high price variation in the area or marketplace. The model could start with historical averages for specific provider groups and move towards historical averages in the geographic area over time.

Using historical data, the prenatal component of an episode budget could be derived from averages based on historical prenatal costs and prorated by the number of months the accountable entity cares for the patient prenatally. The delivery budget could be derived from a blended vaginal and c-section rate based on historical c-section rates, and adjusted based on patient demographics, historical comorbidities, and concurrent risk factors. These adjustments will help to address health equity by recognizing the need to modify based on the particular population a provider serves and not penalizing providers who may serve relatively more individuals who face social risk factors. If newborns are included in the episode's patient population, a newborn budget could be derived from averages based on historical costs for newborns by nursery level, and it could include a stop loss cap to protect providers from catastrophic risk.

An alternative to utilizing historical data to develop the episode budget would be to identify the expected services within an episode and use payer rates to build an episode budget "from the ground up." This would set "ideal" budgets that eliminate price variation, but it would be very labor- and data-intensive, and likely controversial with providers.

Another alternative to episode-specific budgets is setting average payment thresholds, which has been utilized by Medicaid programs in Tennessee, Ohio, and Arkansas. Thresholds are based on average historical costs and guide whether a provider is able to share in savings, is subject to penalty, or has no change in payment. Setting thresholds based on the performance of all providers has allowed the states to make their episode-based payment "budget neutral," since an equal number of providers are penalized as are rewarded.

The Sub-Group recommends that cost variation between subpopulations should be considered to accurately set episode budgets, but payers and providers should avoid unintentionally embedding existing payment issues and health equity barriers when setting an episode's price. Specifically, it is important to test population and budget assumptions to ensure that a provider

that sees relatively more individuals who face racial and ethnic disparities are not penalized based on having a relatively higher budget based on those inequities.

Aligned Quality Measures

As with quality measures for primary care, a quality measurement strategy for a maternity care episode that is aligned across insurers, with manageable reporting requirements, helps minimize administrative burden on practices and improves the likelihood that providers will focus on highest priority quality improvement opportunities and achieve improved performance for their patients and reduce health care disparities.

Central to the Sub-Group's discussion on quality measures was alignment with quality measures already in use in Colorado and the use of standardized measures derived from national quality measure sets, with particular emphasis on the CMS core quality measures, as Colorado Medicaid is required to report on those measures and which measures support reductions in health disparities. To guide decisions about the inclusion of quality measures in a Maternity Care Aligned APM, the Sub-Group reviewed:

- Comparable state and federal quality measure sets, including CMS' 2022 maternity core measure set, measures used in HCPF's maternity care episode, and Colorado's 2021 Hospital Quality Incentive Payment (HQIP) Program maternal health and perinatal care measures;
- Colorado's Medicaid and commercial performance on HEDIS measures relative to national benchmarks, with special attention to measures with poorer state performance, and
- Other states' aligned quality measures work and experiences.

Included in Attachment C is a complete inventory of maternity care quality measures reviewed by the Sub-Group.

The Sub-Group recommends that maternity care APMs include quality measures from an aligned measure set for maternity care, which include measures from the prenatal, birth, and postpartum phases of maternity care. Certain measures should be linked to financial incentives while others should be included for monitoring purposes only; these measures are summarized in Figures 7 and 8 below.

Figure 7: Maternity Care Measures to be Linked to Financial Incentives

Prenatal	Behavioral Health Risk Assessment (for Pregnant Women[7]) *Source: EHR data*
Birth	Cesarean Rate for Nulliparous Singleton Vertex (PC-02) *Source: Claims*
Postpartum	Postpartum Depression Screening and Follow-Up (PPD) *Source: Claims/Hybrid*

Figure 8: Maternity Care Measures to be Used for Monitoring Purposes Only

Prenatal	Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH) *Source: Claims/Hybrid*
Birth	Reduction of Peripartum Racial & Ethnic Disparities *Source: EHR*
	Severe Maternal Morbidity *Source: EHR*

Providers and payers have autonomy to choose which of these or other measures to include in APMs and report on, but for selected measures, payers should use consistent measure definitions and specifications, as identified in Attachment D, Maternity Care Quality Measures Technical Specifications, to minimize the burden on providers. In setting performance targets, the Sub-Group noted the importance of considering provider-specific performance as a starting place, where the focus is on provider improvement rather than historical performance across a geographic area or marketplace.

The Sub-Group recognizes the importance of moving metrics over time to be focused more on outcomes and preventable maternal morbidity and mortality, which is very high for populations

[7] We recognize the importance of gender inclusive language and have incorporated this terminology throughout the report, however, in this instance we did not alter the terminology of the actual quality measure name. Refer to the measure details on the Agency for Healthcare Research and Quality website: https://www.ahrq.gov/pqmp/measures/risk-assessment-pregnant-women.html.

of color. One way to do that is to transition the "reporting-only" measures identified above to be incentive measures over time. In addition, the Sub-Group stressed the importance of stratifying quality measures to better understand where disparities exist as a next step. Given current challenges with data collection, the Sub-Group did not want to mandate such requirements but recommends that payers incentivize practices to stratify quality measure results by race and ethnicity. If such analyses identify disparities in health care quality or outcomes, practices and payers should collaborate to develop a quality improvement action plan that seeks to reduce identified disparities. The Sub-Group recommends ongoing learning and monitoring of national efforts to collect, assess and act on health disparities data, and to revisit these requirements in the future.

Risk Adjustment

As noted above, risk adjustment is an actuarial method used to account for the health status of a patient population. When applied to payment, risk adjustment helps to account for underlying differences in patient populations served by different maternity care providers. The goal is to reduce the incentive for providers to seek out healthier patients and turn away sicker patients. Payment may be adjusted based on the age and sex distribution of the panel or may include more sophisticated methodologies that reflect the clinical and social profile of the patient population. The Maternity Care Sub-Group recommends the following principles when using risk adjustment methods in maternity care APMs:

- Payers, when utilizing a risk adjustment methodology of their choosing, which may include risk adjustment methodologies currently in use, should be transparent with practices about the methodology used and how it is applied to payments.

- The group felt it important to ensure that methods used in risk adjustment models do not disadvantage any patient populations.

Additionally, the group agreed that for patients who are outliers and fall on either extreme of the risk continuum (i.e., very low risk or very high risk), payers and providers may consider removing these outliers in calculating performance against the episode budget.

Patient Attribution

When using patient attribution methods in Colorado's maternity care APMs, the Sub-Group recommends that payers utilize a patient attribution methodology of their choosing, but be transparent regarding the methodology. Additionally, the Sub-Group recommends that payers and providers, together, should practice strong bilateral communications to resolve patient attribution issues and challenges.

Provider/Practice Support

The Sub-Group recognized that the level of expertise and business acumen necessary to transition to APMs and facilitate maternity care practice transformation is not equal across all providers. Some maternity care practices may need or benefit from support from payers or other external resources to help them prepare for, implement, and monitor APMs. The Sub-

Group highlighted the following technical assistance and education support they recommend payers offer to practices:

- **Timely, high-quality APM cost and quality performance data** in a format that can be used for comparison against budgets, benchmarks, and performance of other maternity care providers in the same market/region, network, or state. Cost and quality performance data should include detailed calculations for any shared savings payments or financial liability. Many providers do not currently have access to data that would be pertinent to an episode of care, such as itemized cost data. The level of data transparency for providers participating in an episode should enable providers to use data-driven insights to make practice transformation decisions. Itemized cost data should include cost at the department level, e.g., pharmacy, lab imaging, etc. Non-disclosure agreements (NDAs) and business associate agreements (BAAs) may be appropriate to enable such data sharing.

- **Sessions on how APMs work**, including a focus on reducing disparities in care and discussion of the financial model, such as actuarial analysis and potential for shared savings or risk, and what the provider might have to do to achieve savings or avoid risk.

- **Assistance on the use of data to manage patients**, including, for example: how to read reports, interpret data, and turn data into action.

- **An assessment of provider APM readiness**, including what providers need to be able to do to participate in a maternity episode and direct support to interested practices to assist in readiness.

Recommended Future Steps

While HCPF has an existing maternity APM, the Department is currently engaged in a process to review its approach and further engage stakeholders. As this occurs, HCPF should consider the findings of this group as well as the lessons learned from their current model. As there was limited payer involvement in the Maternity Care Sub-Group, we recommend that the State discuss the outcomes of this group and HCPF's revised maternity APM, when complete, with payers to work toward greater alignment of maternity care APMs across payers.

In addition, there are several aspects of the episode model that will require more attention.

- **Health equity**: Continue to explore how to use maternity care APMs to further health equity.

- **Patient attribution**: Explore best practices and approaches to improve patient attribution.

- **Risk adjusted payments**: Explore approaches for incorporating social risk into risk adjusted payments.

- **Promising practice transformation supports:** Identify current and promising practice transformation supports and resources to facilitate the implementation of maternity care APMs.

Conclusion

Lessons Learned

Lessons learned from this work are important to keep in mind as Colorado transitions to continued stakeholder engagement for maternity care APMs and continued stakeholder discussions and implementation planning for primary care APMs:

- **Stakeholder engagement**: Stakeholder engagement varied across the maternity care and primary care APM Sub-Groups. Primary care discussions included engaged participants representing public and commercial payers, primary care providers, consumer advocates, and primary care professional associations, whereas the commercial payer representation in the maternity care discussions was limited. Both groups included consumer advocates who shared the consumer/patient perspective, however, the direct patient perspective was not represented in the discussions. As the State moves forward, it will be important to more actively engage both commercial insurers and patients/consumers in APM design and implementation.
- **Importance of equity**: While health equity was established as a priority for both APM initiatives and considered throughout APM development, health equity cannot be solved through a reimbursement model alone. Health equity must be considered in the broader context of both primary and maternal care delivery ***and*** reimbursement models. Data collection and performance reporting is another important aspect of addressing equity. The state may consider a standard approach for doing so across all payers.
- **Different types of providers necessitate different approaches**: Primary care discussions highlighted the need to consider and adopt different APM approaches for the care of adults and children. This report highlights the challenges that pediatricians face with current APM methods, which have been largely designed for adult populations, and suggests different approaches. However, the report does not include specific approaches to address these challenges. The state may want to explore this further, including the identification of specific approaches that will work best for practices that care for children. Likewise, maternity episodes may differ depending on what type of provider is willing to serve as the accountable entity. Once the responsible provider is identified, other components of a maternity episode may be finalized.
- **Public payers are bound to federal requirements**: Discussions in both Sub-Groups highlighted federal requirements that HCPF, as a public payer, must adhere to that commercial payers are not bound by. While HCPF was an active and flexible participant, the Department made clear that its limited resources will need to first go towards prioritizing federal requirements. As the State considers further APM design and implementation work, it should be mindful of public payers' requirements and possible limitations in a multi-payer initiative.

Operational Next Steps

The table below summarizes the actions steps we recommend the state take to begin operationalizing the report recommendations.

Action Step	Timeframe
1. The state should transition priority primary care APM topics, as recommended in this report, to its work with the HCP-LAN STC.	Spring/Summer 2022
2. Following its work with the HCP-LAN STC, the state should make final primary care aligned APM recommendations.	Ongoing
3. The state should establish a governance mechanism to ensure Primary Care Aligned APM requirements are correctly implemented and that payers and providers comply with the requirements, once finalized and approved by the state.	Summer 2022
4. HCPF should continue to assess its Maternity Care APM approach and decide next steps, leveraging the findings and recommendations in this report and further stakeholder engagement that includes commercial payers.	Fall 2022
5. The state should continue to consider health equity in its approaches to primary care and maternity care APMs.	Ongoing

Appendix A: Stakeholder Groups Membership Roster

	Name	Organization	Advisory Group	Primary Care Sub-group	Maternity Care Sub-group
1	Ellen Brilliant	AAP Colorado	X	X	X
2	Kelly Campbell	AHIP	X	X	
3	Cassana Littler, MD, FAAP	American Academy of Pediatrics, Colorado Chapter	X	X	X
4	David Keller MD, FAAP	American Academy of Pediatrics, Colorado Chapter	X	X	X
5	Chris Botts	American Medical Association		X	
6	Becky Yowell	American Psychiatric Association	X	X	
7	Andrew Carlo, MD	American Psychiatric Association		X	
8	Christopher Riley	Anthem	X	X	
9	Janet Pogar	Anthem	X		
10	Erin Hoffman	Banner Health			X
11	Polly Anderson	CCHN	X	X	
12	Christina Yebuah	CCLP	X	X	X
13	Rayna Hetlage	Center for Health Progress	X	X	
14	Dustin Allison	Center for Medicare and Medicaid Innovation (CMMI)	X	X	
15	Kathryn Davidson, LCSW	Center for Medicare and Medicaid Innovation (CMMI)	X	X	
16	Rehana Gubin	Center for Medicare and Medicaid Innovation (CMMI)	X	X	
17	Katherine Riley	COLOR			X
18	Ryan Biehle	Colorado Academy of Family Physicians	X		
19	Stephanie Gold	Colorado Academy of Family Physicians		X	
20	Charity Lehn, MD	Colorado Academy of Family Physicians			X
21	Stephanie Glover	Colorado Access	X	X	X
22	Janet Milliman	Colorado Access	X	X	X
23	Kathryn Burch	Colorado Access	X	X	X
24	Gretchen McGinnis	Colorado Access	X	X	X
25	Jane Reed	Colorado Access	X	X	X
26	Sarrah Knause	Colorado Access		X	X
27	Elisa Patterson	Colorado Affiliate American College of Nurse Midwives			X
28	Amanda Massey	Colorado Association of Health Plans	X	X	X
29	Sue Williamson	Colorado Children's Healthcare Access Program (CCHAP)	X		
30	Mindy Craig	Colorado Children's Healthcare Access Program (CCHAP)	X		
31	Chris Kennedy	Colorado General Assembly	X		
32	Ling Cui	Colorado Health Care Policy and Financing	X		
33	Darlene Tad-y	Colorado Hospital Association	X	X	X

	Name	Organization	Advisory Group	Primary Care Sub-group	Maternity Care Sub-group
34	Ali Rosenberg, MPH	Colorado Hospital Association			X
35	Mandy Seader	Colorado Hospital Association			X
36	Richard Bottner	Colorado Hospital Association	X	X	X
37	Sami Diab	Colorado Medical Society; Self	X	X	
38	Colleen Casper	Colorado Nurses Association	X		
39	Brace Gibson, J.D.	Colorado Perinatal Care Quality Collaborative	X		X
40	Michelle Mills	Colorado Rural Health Center	X	X	
41	Kelly Erb	Colorado Rural Health Center	X		
42	Marcy Cameron	CRHC	X	X	X
43	Daniel Jacobson, MD	CU Medicine Obstetrics & Gynecology - East Denver (Rocky Mountain)			X
44	Marc Reese	CVS/Aetna	X		
45	Tim Giess	CVS/Aetna	X		
46	Mary Greer Simonton	Deloitte	X	X	
47	Susan Budd	Denver Health	X		
48	mwansa koranteng	Denver Health	X		
49	Spencer McClelland, MD	Denver Health and Hospital Authority			X
50	Kelly Stainbeck-Tracy, MPH	Denver Public Health, Maternal and Child Health Program			X
51	Josh Benn	Department of Personnel & Administration	X	X	X
52	Indra Wood Lusero	Elephant Circle			X
53	Heather Thompson	Elephant Circle			X
54	Anne Saumur	HCPF		X	
55	Susanna Snyder	HCPF	X		X
56	Ke Zhang	HCPF			X
57	Adam Schafer	HCPF	X	X	X
58	Dallin Anderson	HCPF	X	X	X
59	Ann Marie Stein	HCPF	X	X	X
60	Nicole Nyberg	HCPF	X	X	X
61	Chloe Wilson	HCPF - PR Division	X	X	X
62	Peter T. Walsh, MD, MPH	HCPF, CMO	X	X	X
63	Andrea Stojsavljevic	Healthier Colorado	X		
64	Kristi Bohling-DaMetz	HealthTeamWorks	X	X	
65	Cecilia Saffold	HealthTeamWorks			X
66	Shannon Groves	Kaiser	X		
67	Sean Kurzweil	MedNax Health Solutions Partner			X
68	Robert Stettler, MD	MedNax Health Solutions Partner			X
69	Jill Atkinson	Mountainland Peds/Community Reach Center	X	X	
70	Isabel Cruz	mountainland Peds/Community Reach Center	X		
71	Carrie Paykoc	Office of eHealth Innovation (OeHI)	X		
72	Isabelle Nathanson	OSPMHC	X	X	X
73	Claire Brockbank	Peak Health Alliance	X		

	Name	Organization	Advisory Group	Primary Care Sub-group	Maternity Care Sub-group
74	Autumn Orser	Peak Vista Community Health Centers	X	X	X
75	Perry Dickinson	Practice Innovation Program at the University of Colorado, Department of Family Medicine	X	X	
76	Sean Oser, MD	Practice Innovation Program, University of Colorado, Department of Family Medicine		X	
77	Patrick Gordon	Rocky Mountain Health Plans	X	X	
78	Robert Smith	The Colorado Purchasing Alliance; The Colorado Business Group on Health	X	X	X
79	Erin Marchant	The Women's Health Group			X
80	Elan Green	TRICARE Health Plan, Chief of Medical Benefits and Provider Reimbursement	X	X	X
81	Beatrice Cahill-Camden	TRICARE Health Plan, Program Analyst for Member Benefits and Reimbursement	X	X	X
82	Dawn Erckenbrack, MD	TRICARE Health Plan, Program Manager for Value-Based Care	X	X	X
83	Sharon Seelmeyer	TRICARE Health Plan, Sr. Reimbursement Specialist	X	X	X
84	Jessica L. Anderson, DNP, CNM, WHNP, FACNM	University of Colorado Anschutz Medical Campus	X		X
85	Christina Reimer, MD	University of Colorado, School of Medicine, Dept of Internal Medicine		X	
86	Stephen M. Scott, MD, MPH, FACOG	University of Colorado, School of Medicine, Dept of Ob/Gyn and Pediatrics			X
87	Kelly Youngberg, MHA	University of Washington, Addictions, Drug & Alcohol Institution		X	
88	Milena Stott	University of Washington, Dept Psychiatry & Behavioral Services, AIMS Center		X	
89	Paul Fishman, PhD	University of Washington, School of Public Health, Dept of Health Systems and Population Health		X	
90	Kyra deGruy Kennedy	Young Invincibles	X	X	X
91	Linda Schiller	Young Invincibles	X	X	X
92	Rebecca Alderfer	ZOMA Foundation	X		X