COLORADO ACCESS

ADMINISTRATIVE PAYMENT MODEL SPECIFICATION DOCUMENT

FY 2022-2023

Introduction

Background:

Colorado Access (COA), as the Regional Accountable Entity (RAE) of Colorado Regions 3 and 5, is tasked with building and managing a robust network of primary care medical providers (PCMPs) that serve as patient-centered medical homes to Health First Colorado Members (Colorado's Medicaid Program). COA aims to create programming that incentivizes medical home practices to employ methods that allow Health First Colorado members to receive high-quality primary care services that are grounded in best practices, which result in the best possible health outcomes.

The patient-centered medical home (PCMH) model is, to date, considered the method that delivers the highest quality of primary care for patients with one or more chronic conditions.[1] Preliminary evidence also shows that the PCMH model produces better clinical outcomes, higher adherence and lower emergency department utilization for low-income populations[2].

COA collaborates and consults with network providers regularly prior to the creation or modification of every component of its value-based payment models. Stakeholder meetings are held approximately six to eight months prior to a new model's inception, where new ideas for the model are vetted by providers to ensure that the model is fair (rewards high performance, is not unfairly punitive, and does not inadvertently include perverse incentives), administratively manageable (minimally burdensome), and progressively focused on improving member health and outcomes.

Purpose:

The purpose of this document is to describe the methodologies used to measure performance for the Colorado Access Administrative Payment Models (APM) in fiscal year (FY) 22-23.

Measurement Period:

The measurement period for baseline performance is based on prior calendar year claims data.

[1]Jackson GL, Powers BJ, Chatterjee R, et al. The patient centered medical home. A systematic review. Annals of Internal Medicine 2013 Feb 5; 158(3):169-78.

[2] Van den Berk-Clark C, Doucette E, Rottnek F, et al. Do patient-centered medical homes improve health behaviors, outcomes, and experiences of low-income patients? A systematic review and meta-analysis. Health Services Research 2018. Jun; 53(3):1777-1798.

General F&Q:

1. **If a Member is dually enrolled with two (2) insurers, would the Member be included in the denominator for these measures?**

   Yes, Members with other insurance would be included in the denominator for these measures. Colorado Access does not have access to other payor source data outside of members that are dually enrolled into Medicare/Medicaid. Members dually enrolled with Medicare/Medicaid have been accounted for in both the numerator and denominator of all metrics in the payment models.

2. **How is credit awarded when there are two (2) insurers present?**

   Credit is awarded to the primary payor on the claim. The secondary payer would only come into play if the service rendered was not covered by the primary payor.

   Once the Public Health Emergency is over, Members with both a commercial and public payor (Medicaid, CHP+) will be redetermined to the appropriate insurer, but again Colorado Access does not have access to commercial payor data to recalculate data.

3. **How is Member churn (moving between Medicaid and another payor) accounted for during the measurement period?**

   A Member that is enrolled with Medicaid and attributed to a provider in the last month of the measurement period (in this case, December, 2021) will be counted in the denominator of each metric they are eligible for (depending on standardized specs that may include age, diagnosis, etc.).

   If a Member ends the measurement period not enrolled in Medicaid, the Member would be scrubbed from the denominator. This is similar to the logic the Department of Health Care Policy and Financing uses for the Key Performance Indicator metrics.

4. **If a Member receives Well-Visit(s) from one provider while attributed to a different provider, which provider would receive credit at the end of the measurement period?**

   HCPF has an attribution clean-up process that happens in June and December to move members that are using a different Primary Care Providers than their attributed Primary Care Provider. The reattribution process should occur each year just prior to the end of Colorado Access's measurement period (late December, 2021), the attributed provider listed at the end of the measurement period would receive numerator credit.

A1c Testing for Diabetics

Colorado Access Administrative Payment Model(s): Family Medicine Model

Measure Name: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing[3]

Steward: NCQA with revisions by COA

NQF #: 0057

HEDIS Measure: No

CMS Core Set Measure: No

Measure Description: The percentage of members ages 18 to 75 with diabetes (type 1 and type 2) who receive an HbA1c test during the measurement period.

Denominator: Members ages 18 to 75 on the COA diabetes registry at the end of the measurement period who had a diagnosis of diabetes (type 1 or type 2) within the last three years.

Numerator: Members who had an HbA1c test (CPT codes 3044F, 3046F, 3051F, 3052F, 83036, or 83037) during the measurement period.

Exclusions: Members with gestational diabetes or members receiving hospice care at any point during the measurement period.

Additional Measure Stratification: N/A

Note: Multiple numerator events in the evaluation period for a unique member will only be counted once. HbA1c tests performed in an outpatient, inpatient, and emergency department setting are included in this measure.

[3] National Quality Forum. *Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C-AD)*. NQF: Quality Positioning System. (2022). https://www.qualityforum.org/QPS/0057.

Child and Adolescent Well-Care Visit

Colorado Access Administrative Payment Model(s): Pediatric and Family Medicine Models

HEDIS/Core Set Measure Name: Child and Adolescent Well-Care Visits (WCV-CH)[4]

Steward: NCQA

NQF #: 1516

HEDIS Measure: Yes

CMS Core Set Measure: Yes

Measure Description: The percentage of members ages 3 to 21 who had at least one comprehensive well visit with a primary care provider or an obstetrician/gynecologist (OB/GYN) during the measurement period.

Denominator: Members ages 3 to 21 during the measurement period.

Numerator: Members ages 3 to 21 who had one or more well visits during the measurement period.

Additional Measure Stratification: N/A.

[4] Center for Medicaid and CHIP Services. (March 2021). *Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2021 Reporting*. 105-106. medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf

Contraceptive Care – Postpartum Women

Colorado Access Administrative Payment Model(s): Reproductive Health Model

HEDIS/Core Set Measure Name: Contraceptive Care – Postpartum Women Ages 15-20 (CCP-CH)[5]
Contraceptive Care – Postpartum Women Ages 21-44 (CCP-AD)[6]

Steward: OPA

NQF #: 2902

HEDIS Measure: No

CMS Core Set Measure: Yes

Measure Description: Among women ages 15 to 44 who had a live birth, the percentage that:

1. **Were provided a most effective or moderately effective method of contraception within three and 60 days of delivery.**
   Numerator: The eligible population that was provided a most or moderately effective method of contraception.
   Denominator: The eligible population includes women ages 15 to 44 who had a live birth in the measurement period.
2. **Were provided a long-acting reversible method of contraception (LARC) within three and 60 days of delivery.**
   Numerator: The eligible population that was provided a LARC method.
   Denominator: The eligible population includes women ages 15 to 44 who had a live birth in the measurement period.

Additional Measure Stratification: Stratified by women ages 15 to 20 and 21 to 44.

The first rate is an intermediate outcome measure, and it is desirable to have a high percentage of women who are provided the most effective or moderately effective contraceptive methods during the postpartum period. The second rate is an access measure, and the focus is on making sure that women have access to LARC methods during the postpartum period.

[5] Center for Medicaid and CHIP Services. (March 2021). *Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2021 Reporting*. 37-40. medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf

[6] Center for Medicaid and CHIP Services. *Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2021 Reporting.* (March 2021). 34-36. medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf

Most effective methods of contraception include female sterilization, contraceptive implants, or intrauterine devices or systems (IUD/IUS). Moderately effective methods of contraception include injectables, oral pills, patch, ring, or diaphragm. Qualifying long-acting reversible methods of contraception (LARC) include contraceptive implants and intrauterine devices or systems (IUD/IUS).

Note: COA does not expect this metric to reach 100%, as some women will make informed decisions to choose methods in the lower tier of efficacy even when offered the full range of methods. The goal of providing contraception should never be to promote any one method or class of methods over women's individual choices.

Question: How is the eligible population (denominator) identified for this measure?

Answer: The eligible population includes women ages 15-44 who had a live birth in the measurement period. Women with a live birth occurring after October 31st will be excluded from the denominator because they may not have an opportunity to receive contraception in the postpartum period (defined as within 60 days of delivery).

Step 1 in identifying the eligible population is to identify claims with live births and deliveries using codes in Table CCP-A of the 2022 Adult and Child non-HEDIS value set directory. Step 2 is to exclude deliveries that did not end up in a live birth (e.g., miscarriage, ectopic, stillbirth, or pregnancy termination) by using codes in Table CCP-B of the 2022 Adult and Child non-HEDIS value set directory. Step 3 is to exclude live births that occurred in the last 2 months of the measurement period. Once these 3 steps are complete, the eligible population (denominator) is identified.

Contraceptive Counseling – All Women Ages 15 to 44

Colorado Access Administrative Payment Model(s): Reproductive Health Model

Measure Name: Contraceptive Counseling – All Women Ages 15 to 44

Steward: Colorado Access

NQF #: N/A

HEDIS Measure: No

CMS Core Set Measure: No

Measure Description: The percentage of women 15 to 44 years of age who receive contraceptive counseling during the measurement period.

Denominator: Women 15 to 44 years of age.

Numerator: Women 15-44 years of age who received contraceptive counseling during the measurement period. Contraceptive counseling is identified through the following logic:

1. Claim billed with an Outpatient E&M (99202- 99205; 99211-99215) or Preventative Medicine (99384-99386; 99391; 99395; 99396; 99401-99404) code.
   AND
2. ICD-10 contraceptive management code (Z30.0; Z30.09; Z30.8; Z30.9; Z31.61).
   OR
3. Claim billed with the FP modifier code.

Additional Measure Stratification: Stratified by women ages 15 to 20 and 21 to 44.

Note: Multiple numerator events in the evaluation period for a unique member will only be counted once.

COA does not expect this metric to reach 100%, as some women will make informed decisions to choose methods in the lower tier of efficacy even when offered the full range of methods. The goal of providing contraception should never be to promote any one method or class of methods over women's individual choices.

Question: How is the eligible population (denominator) identified for this measure?

Answer: The eligible population includes women ages 15-44 who received contraceptive counseling during the measurement period. Women are identified using the Colorado Department of Health Care Policy & Finance (HCPF) enrollment (834) data file. Members report enrollment data to HCPF at the initial time of enrollment and during the yearly re-enrollment period. Members may update their enrollment data by contacting HCPF Customer Service.

Medication Adherence – Asthma

Colorado Access Administrative Payment Model(s): ECP Model

HEDIS/Core Set Measure Name: Asthma Medication Ratio: Ages 5 to 18 (AMR-CH)[7]
Asthma Medication Ratio: 19 to 64 (AMR-AD)[8]

Steward: NCQA

NQF #: 0541

HEDIS Measure: Yes

CMS Core Set Measure: Yes

Measure Description: The percentage of members ages 5 to 64 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement period.

Denominator: All members ages 5 to 64 who have persistent asthma by meeting at least one of the following criteria during both the measurement period and the year prior to the measurement period:

- At least one emergency department visit with asthma as the principal diagnosis.
- At least one acute inpatient encounter or discharge with asthma as the principal diagnosis.
- At least four outpatient visits, observation visits, telephone visits, or online assessments on different dates of service, with any diagnosis of asthma AND at least two asthma medication dispensing events for any controller or reliever medication. Visit type need not be the same for the four visits.
- At least four asthma medication dispensing events for any controller medication or reliever medication.

Numerator: The number of members with persistent asthma who have a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement period.

Exclusions: 1) Members who had any of the following diagnoses any time during their history through the end of the measurement period:

[7] Center for Medicaid and CHIP Services. (March 2021). *Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2021 Reporting*. 31-36. medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf

[8] Center for Medicaid and CHIP Services. *Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2021 Reporting.* (March 2021). 26-31. medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf

- Chronic obstructive pulmonary disease (COPD)
- Emphysema
- Obstructive chronic bronchitis
- Chronic respiratory conditions due to fumes/vapors
- Cystic fibrosis
- Acute respiratory failure

2) Members who had no asthma medications (controller or reliever) dispensed during the measurement period.

3) Members in hospice.

Additional Measure Stratification: N/A

Medication Adherence – Diabetes

Colorado Access Administrative Payment Model(s): ECP Model

Measure Name: Proportion of Days Covered: Diabetes All Class[9]

Steward: Pharmacy Quality Alliance

NQF #: 0541

HEDIS Measure: No

CMS Core Set Measure: No

Measure Description: The percentage of individuals age 18 and older who met the Proportion of Days Covered (PDC): Diabetes All Class threshold of 80 percent during the measurement period.

Denominator: Members age 18 years and older with at least two prescription claims for medication(s) within the diabetes therapeutic category on different dates of service

Numerator: The number of members who met the PDC threshold of 80 percent during the measurement period.

Exclusions: Members with one or more prescription claims for insulin, members in hospice, and members with end-stage renal disease during the measurement period.

Additional Measure Stratification: N/A

[9] Pharmacy Quality Alliance. (October 2019). *Proportion of Days Covered: Diabetes All Class (PDC-DR)*. pqaalliance.org/measures-overview#pdc-dr.

Screening for Depression (Engaged Members)

Colorado Access Administrative Payment Model(s): All Models

HEDIS/Core Set Measure Name: Screening for Depression and Follow-Up Plan: Age 12 to 17 (CDF-CH)[10]
Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)[11]

Steward: NCQA with revisions by COA

NQF #: 0418

HEDIS Measure: Yes

CMS Core Set Measure: Yes

Measure Description: Percentage of engaged members age 12 and older screened for depression using an age-appropriate standardized depression screening tool and, if positive, a follow-up plan is documented on the date of the eligible encounter.

Denominator: All engaged members age 12 and older at the beginning of the measurement period with at least one eligible encounter during the measurement period. Eligible encounters include depression screens that take place in an outpatient setting.

Numerator: Engaged members age 12 and older who received a depression screen as indicated by G8431 (screening for depression is documented as being positive and a follow-up plan is documented) or G8510 (screening for depression is documented as negative, a follow-up plan is not required) in an outpatient setting.

> **HCPF Billing Rule:** Beginning **January 1, 2023**, a billing modifier on ALL depression screens delivered to Members using G8431 (screening for depression is documented as being positive and a follow-up plan is documented) or G8510 (screening for depression is documented as negative, a follow-up plan is not required) will be required. Senate Bill 21-137 requires depression screens delivered to any caregiver of a child enrolled in Health First Colorado to be covered. The addition of a caregiver

[10] Center for Medicaid and CHIP Services. (March 2021). *Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2021 Reporting*. 53-59. medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf

[11] Center for Medicaid and CHIP Services. *Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2021 Reporting.* (March 2021). 53-59. medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf

screen requires providers to include modifiers to track when a screen is done for the individual whose Health First Colorado ID the screen is billed under, for the parent who gave birth to the Member, or for a caregiver to the Member. The table below outlines how depression screens will need to be billed starting January 1, 2023. Modifiers may be used in any position on the detail line.

Relationship to Member ID on Claim	Unique Modifier
Self	U1
Parent who gave birth to Member	U2
Other primary caregiver to Member	U3

Exclusions: Members with an active diagnosis of depression or bipolar disorder, as defined by the presence of an ICD-10 diagnosis code on a claim received in the past 12 months. Screens billed with unique modifier U2 or U3.

Exceptions: Members who do not meet the numerator criteria and meets the following exception criteria will be removed from the denominator.

- Member refusal.
- Member is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the member's health status.
- Situations where the member's cognitive capacity, functional capacity, or motivation to improve may impact the accuracy of results of nationally recognized standardized depression assessment tools. For example, certain court-appointed cases or cases of delirium.

The screening code to identify exceptions is G8433 (screening for depression not completed, documented reason).

Additional Measure Stratification: Member's ages 12 to 20 and 21 and up.

Note: Practices participating in the COA APM will not be measured on the documentation of a follow-up plan portion of this measure. The expectation is for every positive depression screen to have a documented follow-up plan on the date of the eligible encounter. The COA practice facilitators will provide coaching around appropriate follow-up plan documentation as needed.

Standardized Depression Screening Tools: Normalized and validated depression screening tool developed for the population in which it is being utilized. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record. Examples of depression screening tools include but are not limited to:

Adolescent Screening Tools (ages 12 to 17)

- Patient Health Questionnaire for Adolescents (PHQ-A)
- Beck Depression Inventory-Primary Care Version (BDI-PC)
- Mood Feeling Questionnaire (MFQ)
- Center for Epidemiologic Studies Depression Scale (CES-D)
- Patient Health Questionnaire (PHQ-9)

- Pediatric Symptom Checklist (PSC-17)
- PRIME MD-PHQ2

Adult Screening Tools (age 18 and older)

- Patient Health Questionnaire (PHQ-9)
- Beck Depression Inventory (BDI, BDI-II)
- Center for Epidemiologic Studies Depression Scale (CES-D)
- Depression Scale (DEPS)
- Duke Anxiety- Depression Scale (DADS)
- Geriatric Depression Scale (GDS)
- Cornell Scale for Depression in Dementia (CSDD)
- PRIME MD-PHQ2
- Hamilton Rating Scale for Depression (HAM-D)
- Quick Inventory of Depressive Symptomatology Self-Report (QID-SR)
- Computerized Adaptive Testing Depression Inventory (CAT-DI)
- Computerized Adaptive Diagnostic Screener (CAD-MDD)

Perinatal Screening Tools

- Edinburgh Postnatal Depression Scale
- Postpartum Depression Screening Scale
- Patient Health Questionnaire 9 (PHQ-9)
- Beck Depression Inventory
- Beck Depression Inventory–II
- Center for Epidemiologic Studies Depression Scale
- Zung Self-rating Depression Scale

Follow-up Plan Requirements: Documented follow-up for a **positive depression screening** *must* include one or more of the following:

- Additional evaluation for depression,
- Suicide risk assessment,
- Referral to a practitioner who is qualified to diagnose and treat depression,
- Pharmacological interventions, or
- Other interventions or follow-up for the diagnosis or treatment of depression.

Examples of qualifying follow-up plans include:

- Additional evaluation or assessment for depression such as psychiatric interview, psychiatric evaluation, or assessment
- Completion of any suicide risk assessment such as Beck Depression Inventory or Beck Hopelessness Scale

Referral to a practitioner or program for further evaluation for depression, for example, referral to a psychiatrist, psychologist, social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression.

Question: Which outpatient codes are included in the denominator?

Answer: The following outpatient CPT codes are included in denominator

59400	59510	59610	59618	90791	90792	90832	90834	90837	92625
96105	96110	96112	96116	96125	96136	96138	96156	96158	97161
97162	97163	97165	97166	97167	99078	99202	99203	99204	99205
99212	99213	99214	99215	99304	99305	99306	99307	99308	99309

99310	99315	99316	99318	99324	99325	99326	99327	99328	99334
99335	99336	99337	99339	99340	99401	99402	99403	99483	99484
99492	99493	99384	99385	99386	99387	99394	99395	99396	99397

Well Visits in the First 15/30 Months of Life

Colorado Access Administrative Payment Model(s): Pediatric and Family Medicine Models

HEDIS/Core Set Measure Name: Well-Child Visits in the First 30 Months of Life (W30-CH)[12]

Steward: NCQA

NQF #: 1392

HEDIS Measure: Yes

CMS Core Set Measure: Yes

Measure Description: The percentage of members who had the following number of well-child visits with a PCMP during the last 15 months. The following rates are reported:

1. **Well-Child Visits in the First 15 Months (Pediatric and Family Medicine Models)**
   Numerator: Number of members who had the following number of well visits with a primary care provider in the last 15 months: six or more well visits on different dates of service on or before the 15-month birthday.
   Denominator: Children who turn 15 months old during the performance period.
2. **Well-Child Visits for Age 15 Months to 30 Months (Pediatric Model)**
   Numerator: Number of members who had two or more visits on different dates between the child's 15-month birthday and 30-month birthday.
   Denominator: Children who turn 30 months old during the performance period.

Additional Measure Stratification: N/A.

Note: The well visit codes that are counted for this measure are available in the proprietary HEDIS specifications. The questions and answers below provide additional detail about the measures for those who are unable to access the HEDIS specifications.[13]

Question: What types of visits generally are included or not included in the definition of a well visit?

[12] Center for Medicaid and CHIP Services. (March 2021). *Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2021 Reporting*. 104-106. medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf

[13] Colorado Department of Health Care Policy & Financing. (July 2021). *The Accountable Care Collaborative (ACC) Key Performance Indicators (KPI) Methodology SFY 2021-2022 Version 1.* 19-20.

Answer: Any well visit procedure code or diagnosis code as recognized by HEDIS. In-person and telemedicine visits are permitted. Well visits include visits by a PCMP or OBGYN and does not have to be with the provider that a member is attributed to. Visits for immunizations only are not included in the calculation. For more information about well visit standards, view the Bright Futures guidelines.

Question: Which telemedicine well visits are permitted with these measures?

Answer: Any well visit code that HEDIS recognizes that has also been approved by Colorado Medicaid policy will be counted in this measure. Telemedicine options for children's well visits were not permitted until mid-November 2020, and this measure may be impacted by the timing of the public health emergency period and any subsequent telemedicine policy changes.

Question: Do well visits before 31 days of age count towards the numerator?

Answer: A visit during the first 31 days of life meets criteria for the measure. The continuous enrollment criteria does not include this timeframe because sometimes it takes this much time for the baby to be officially enrolled in the health plan. Visits which occur prior to the member's enrollment may be counted towards the measure. For more information about well visit standards, view the Bright Futures guidelines.

Question: Do multiple visits on the same date count toward the measure?

Answer: No, visits must be distinct with different service dates of at least 14 days between them. For example, if a provider were to see a member at age three to five days and again at age 14 days only one visit would count toward the six-visit requirement.