COLORADO ACCESS

PEDIATRIC ADMINISTRATIVE PAYMENT MODEL PROGRAM

FY 2023-24 PROGRAM DOCUMENT

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Contents

I. 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 (Colorado's Medicaid program) members. 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, grounded in best practices, which result in the best possible health outcomes.

The patient-centered medical home (PCMH) model is, to date, considered the vehicle 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 (ED) utilization for low-income populations[2].

Colorado Access regularly collaborates and consults with network providers prior to the creation or modification of its value-based payment models. Stakeholder meetings are held approximately nine to 12 months prior to a new model's inception, where new ideas for the model are vetted by providers to ensure that the model is aligned with common priorities, fair (rewards high performance, is not unreasonably punitive, and does not inadvertently include perverse incentives), administratively manageable (minimally burdensome), and progressively focused on improving member health and outcomes.

The **COA Administrative Payment Model Specification document** describes the methodology COA has taken for calculating measure performance and can be found online at coaccess.com/providers/resources/vbp.

II. All-Network Provider Site Payments:

There are three potential payments that all PCMPs may receive under Addendum 1:

- Utilizer payment
- Non-utilizer payment

[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.

- KPI and Performance Pool incentive payments

A site's overall utilizer payment is determined according to their performance on metrics related to member engagement, medical home standards, preventative care, and chronic condition management. All provider site types (PCMPs, PCMP+s, and ECPs) will be scored on the five metrics which make up the utilizer payment. Additionally, all provider site types are eligible to receive the four different payment types as outlined below.

Measures carried over from previous models are denoted in black.

Payment # 1 – Utilizer Payment. A site's utilizer payment is calculated according to provider performance on five metrics: 1) **engagement rate score,** 2) **practice assessment score,** 3) **screening for depression score,** 4) **well-visits in the first 15 months of life score,** and 5) **well visits in the first 15 to 30 months of life score**. Performance across these metrics is used to determine the site's overall utilizer payment. Providers will not receive a utilizer payment for members identified as non-utilizers.

***Engagement Rate Score*.** The total number of unique attributed members for which the provider has submitted at least one claim in the previous calendar year (from any PCMP site within the provider's tax ID), calculated as a percentage of the practice site's total attributed members. Attribution will be based on the number of attributed members the practice was assigned in the last month of the measurement period (December 2022). The engagement rate and practice assessment scores are blended as demonstrated in Figure 1.

Example: PCMP X provided billable services to 575 of their 1000 attributed members in the 12-month measurement period. Provider X's engagement rate is 57.5%.

Note: If the provider or COA identifies an attribution anomaly, each party must notify the other party in writing as soon as the anomaly is detected. Attribution is determined by the Department of Health Care Policy and Financing (HCPF) and reported to COA. Once the issue is confirmed by COA, anomalies will be addressed by substituting the average attributed membership of the last six months of the previous calendar year's attributed membership.

***Practice Assessment Score*.** The practice assessment measures site compliance with provider responsibilities as they are outlined in Addendum 1. The assessment focuses primarily on the presence of the key elements of the patient-centered medical home model (PCMH). The practice assessment score is blended with the

site's engagement rate score as demonstrated in Figure 1. Individual site responses are available from the practice support team at practice_support@coaccess.com upon request.

Figure 1: Utilizer Payment – Engagement Rate and Practice Assessment PMPM Scoring Criteria

Engagement Rate			
Lower Bound	Upper Bound	Level	PMPM Amount
0%	29%	None	$0.00
30%	66%	Mid	$0.50
67%	100%	Max	$0.75

Practice Assessment			
Lower Bound	Upper Bound	Level	PMPM Amount
0%	90%	None	$0.00
91%	96%	Mid	$0.25
97%	100%	Max	$0.50

Screening for Depression Score (Engaged Members Only). The total number of unique *engaged* members age 12 and older who received an outpatient depression screen, as documented on a claim, in the previous calendar year, calculated as a percentage of the practice site's total engaged members age 12 and older. Screens that occur at practices outside of the provider's organization *will* be counted toward the site's performance on this metric. Scoring and associated PMPM payment is demonstrated in Figure 2.

Figure 2: Utilizer Payment – Screening for Depression (Engaged Members Only) PMPM Scoring Criteria

Engaged Depression Screen 12+			
Lower Bound	Upper Bound	Level	PMPM Amount
0%	30%	Min	$0.50
31%	69%	Mid	$1.25
70%	100%	Max	$1.75

Well Visits Within the First 15 Months of Life. The total number of unique attributed members who received six or more well visits on or before the member's

15-month birthday, calculated as a percentage of the site's attributed membership that turned 15 months old during the measurement period. Scoring and associated PMPM payment is demonstrated in Figure 3.

Well Visits in the First 15-30 Months of Life. The total number of unique attributed members who received two or more well visits between the members 15-month and 30-month birthday, calculated as a percentage of the practice site's membership who turned 30 months old during the measurement period. The well visit within the first 15 months of life and well visits for ages 15 to 30 months scores are blended as demonstrated in Figure 3. Up to an additional $1.25 PMPM will be added to the site's utilizer payment depending on performance.

Note: If a practice site does not have 10 attributed members that would be eligible for the *Well Visits Within the First 15 Months of Life* denominator **or** the *Well Visits Within the First 15 to 30 Months of Life* denominator during the measurement period, the practice site will be evaluated on and receive payment for achievement on the *Child and Adolescent Well Care Visits* metric. See Figure 3, below, for scoring and associated PMPM payment.

Figure 3: Utilizer Payment – Well Visits Within the First 15 Months and Well-Visits 15 to 30 Months of Life PMPM Scoring Criteria

W15 Screening		
Lower Bound	**Upper Bound**	**Points**
0%	39%	1
40%	67%	2
68%	100%	3

W30 Screening		
Lower Bound	**Upper Bound**	**Points**
0%	60%	1
61%	75%	2
76%	100%	3

Score Determines PMPM Payment

1-2 = $.50 **3-4 = $1.25** **5-6 = $2.00**

Payment #2 – Non-Utilizer Payment. Providers will receive $0.50 PMPM for members

classified as non-utilizers.

Utilizer and Non-Utilizer Payment Example:

Site with minimum number of members for well visits 0 to 30 months of life:

Provider X has a total attributed membership of 2,000 at the end of December 2022, with the minimum number of members eligible for the well visits 0 to 15 months and 15 to 30 months of life metrics.

Provider X received a 57% engagement rate and earned a score of 89% on their most recent practice assessment. They screened 21% of their engaged members for depression, 72% of members received six or more well visits by their 15-month birthday, and 47% of members received two or more well visits between the 15 and 30-month birthday.

Utilizer Payment (Payment #1):

Engagement Rate	(57%)	= $0.50 PMPM (Max Level)
Practice Assessment Score	(89%)	= $0.00 PMPM (None Level)
Screening for Depression	(21%)	= $0.50 PMPM (Mid Level)
Well-visits 0-15 Months	(72%)	= 3 points
Well-visit 15-30 Months	(47%)	= 1 point
		= $1.25 PMPM (4 point, Mid Level)
		= $2.25 PMPM Total

Monthly Payment = ($2.25 * 1,900 Utilizers) + ($0.50 * 100 Non-Utilizers) (**Payment #2**)
= **$4,325.00**

Site without minimum number of members for well-visits 0 to 30 months of life:

Provider X has a total attributed membership of 2,000 at the end of December 2022, without the minimum number of eligible members for the well visits 0 to 15 months and 15 to 30 months of life metrics.

Provider X received a 57% engagement rate and earned a score of 89% on their most recent practice assessment. They screened 21% of their engaged members for depression, and 57% of members ages 3 to 21 received one or more well visits during the year.

Utilizer Payment (Payment #1):

Engagement Rate	(57%)	= $0.50 PMPM (Max Level)
Practice Assessment Score	(89%)	= $0.00 PMPM (None Level)
Screening for Depression	(21%)	= $0.50 PMPM (Mid Level)
Child &Adolescent Well-Visits 3-21 Years	(57%)	= $2.00 PMPM (Max Level)
		= $3.00 PMPM Total

Monthly Payment = ($3.00 * 1,900 Utilizers) + ($0.50 * 100 Non-Utilizers) (**Payment #2**)
= **$5750.0**

III. Key Performance Indicator (KPI) and Performance Pool Payments

Payment #3 – KPI & Performance Pool Incentive Payment KPI and Performance Pool incentive payments are earned through HCPF's Pay-for-Performance program at the

regional level and are distributed to providers by the RAE. The **Pay-for-Performance Incentive Sharing Program document** outlines the KPIs and other pay-for-performance metrics and is posted online at coaccess.com/providers/resources/vbp. Depending on the KPI, payments will be made on a quarterly or annual basis.

IV. PCMP+ and ECP Sites: Complex Member Payments

A subset of provider site types (PCMP+ and ECP) are eligible for an enhanced PMPM payments for complex members, if they demonstrate adequate engagement with their attributed complex member population. Provider payment is contingent on each site's ability to care manage complex members *and* report care plan activities back to the RAE in a required format.

Payment #4 – Complex Member Payment. Providers shall receive a PMPM for each complex member attributed to the site(s). If the provider receives the complex member payment for a member, they are not entitled to the utilizer payment for the same member. This is a monthly payment. Measures carried over from previous models are denoted in black, while new measures are in blue.

A site's complex member payment is calculated according to each eligible site's performance on two metrics, complex claims engagement and complex extended care coordination engagement These two metrics are blended to determine a site's complex member payment, Figure 4.

Complex Claims Engagement Rate. The percentage of unique attributed complex members who had a claim with one of the PCMP+/ECP's sites in the 12-month measurement period.

Complex Extended Care Coordination Rate. The percentage of members that received extended care coordination in the 12-month measurement period.

Figure 4: Complex Member Payment - Complex Member PMPM Scoring Criteria

Complex Engagement Rate		
Lower Bound	Upper Bound	Points
0%	50%	0
51%	65%	1
66%	80%	2
81%	100%	3

Complex ECC Rate		
Lower Bound	Upper Bound	Points
0%	10%	0
11%	25%	2
26%	49%	4
50%	100%	6

Score Determines PMPM Payment

0 = Utilizer PMPM	**1-3 = $5.00**	**4-7 = $10.00**	**8-9 = $15.00**

Complex Member Payment Example:

Provider Y has provided billable services to 75 of their 100 complex members. The care coordination report they provide to COA demonstrates that they have engaged 34 of their complex members in extended care coordination.

Complex Claims Engagement Rate (75%) = 2 points

Complex Extended Care Coordination Rate (34%) = 4 points

Total Score of 6 = $10.00 PMPM

$10.00 PMPM (**Payment 4**) * 100 complex members, therefore

Provider Y's Month 1 Complex Payment = $1,000.00

V. ECP Sites: Care Management Payments

ECPs are paid an additional PMPM payment to provide care management services to their attributed members and to report their care management activities to COA in a required reporting format. All ECPs receive this payment.

Payment #5 – ECP Care Management Payment. ECP shall receive a care management PMPM for each Member attributed to the ECP's site(s). The PMPM amount will be

determined by the ECPs performance score across the three components, Figure 6. Individual site responses and scores are available from the practice support team at practice_support@coaccess.com upon request. This is a monthly payment. Metrics from previous models are denoted in black.

Care Plan Score. The Care Plan component of the COA ECP assessment is a review of a practice's submission of three members' individualized care plans. Individual site responses and scores are available from the practice support team at practice_support@coaccess.com upon request.

Unlimited Panel Score. The Unlimited Panel Score is determined based on whether or not the practice has unlimited attribution, as recorded by HCPF's records. Practice panel status can be verified or changed by emailing practice_support@coaccess.com .

Overall Care Management Engagement Rate. The Overall Care Management Engagement Rate is the percentage of unique attributed members who received care management services within the previous measurement period.

Figure 5: ECP Care Management Payment - PMPM Scoring Criteria

Case Review Results		
Lower Bound	**Upper Bound**	**Points**
0	35	0
36	40	1
41	42	2

Unlimited Panel	
Unlimited Panel Status	**Points**
N	0
Y	1

All Population Care Coordination		
Lower Bound	**Upper Bound**	**Points**
0%	9%	0
10%	20%	1
21%	40%	2
41%	76%	3
77%	100%	4

Score Determines PMPM Payment

0-3 = $2.50 **4-5 = $3.25** **6-7 = $4.00**

Payment #6 – Medication Adherence Add-on Payment. ECP sites may earn up to an additional $1.00 PMPM if they can demonstrate high levels of medication adherence in their attributed members with asthma, Figure 7. **Practices must have at least 20 attributed asthmatic members to qualify for this payment.** This add-on payment will be added to the ECP Care Management Payment.

Figure 6: ECP Care Management Payment – Medication Adherence Add-on PMPM Scoring Criteria

Asthma			
Lower Bound	Upper Bound	Level	PMPM Amount
0%	59%	None	$0.00
60%	65%	Mid	$0.50
66%	100%	Max	$1.00

ECP Care Management Payment Example:

Provider Y has 100 members attributed to their site and has unlimited attribution for Health First Colorado members. Provider Y received a 96% on their care plan reviews and has engaged 14% of their attributed membership with care management. Provider Y has additionally kept 61% of their asthmatic members compliant with their medication(s).

ECP Care Management Payment (Payment #5):

Care Plan Score (96 points) = 1 point

Unlimited Panel Score (Yes) = 1 point

Overall Care Management Engagement Rate (14%) = 1 point

Total Score of 3 = $2.50 PMPM

ECP Medication Adherence Add-on Payment (Payment #7):

Asthma Medication Adherence (61%) = 1 point; $0.50 PMPM

Total Score of 1 = $0.50 Add-on PMPM

$2.50 PMPM (**Payment #5**) + $0.50 PMPM for Medication Adherence performance (**Payment #6**), therefore Provider Y receives **$3.00 PMPM**.

Monthly Payment = $3.00 PMPM * 100 members

= **$300.00**

VI. Glossary:

Care management/care coordination: The deliberate organization of member care activities between two or more participants (including the member and/or family members/caregivers) to facilitate the appropriate delivery of physical health, behavioral health, functional long-term services and supports (LTSS), oral health, specialty care, and other services. Care coordination may range from deliberate provider interventions to coordination with other aspects of the health system to interventions over an extended period by an individual designated to coordinate a member's health and social needs.

Complex member: A COA-defined subset of members determined by factors that may include but are not limited to condition, acuity, and ability to impact through intervention. COA determines whether a member is classified as a complex members.

Complex claims egagement rate: The percentage of attributed complex members who had a claim with one of the ECP's or primary care medical provider plus' ("PCMP+") sites in the previous 12 months.

Complex extended care coordination rate ("ECC engagement rate"): The percentage of attributed complex members who received extended care coordination in the previous 12 months.

Engagement rate: The total number of unique attributed Medicaid members for which a provider has submitted at least one claim in the previous calendar year (from any PCMP site within the provider's tax ID), calculated as a percentage of the practice site's total attributed member panel.

Health First Colorado (Colorado's Medicaid program): Colorado's Medicaid program. It was re-named July 1, 2016.

Key Performance Indicators (KPIs): Performance measures tied to incentive payments for the Accountable Care Collaborative.

Measurement period: The calendar year prior to the start date of the new program. If the program begins on July 1, 2022, the measurement period is calendar year 2021.

Medical home: An approach to providing comprehensive primary care that facilitates partnerships between individual members, their providers, and where appropriate, the member's family.

Member attribution: As applicable to the RAE, those members attributed to the provider by HCPF under a benefit program or otherwise provided for under the RAE and based on claims

history. The number of members attributed to a provider is subject to periodic adjustment by HCPF.

Non-utilizer: A currently eligible member that has not received a service resulting in a paid Medicaid claim in the previous 18 months.

Performance Pool: The HCPF Performance Pool is comprised of set aside funding from the administrative per member per month amount as well as unearned money from the Key Performance Indicators (KPIs). These performance measures are intended to place greater emphasis on health outcomes and cost containment.

Per member per month (PMPM).:A fixed reimbursement methodology for a provider, for attributed and/or assigned members, paid monthly.

Practice assessment score: The score that resulted from each practice site's most recent evaluation in accordance with the agreement and applicable addendum(s).

Primary care medical provider (PCMP): A physician who is a participating provider and who is responsible for coordinating and managing the delivery of covered services to members who have selected or been assigned to such physician. In addition, PCMPs are defined by the following services provided: health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis, and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, day care, etc.). PCMPs are PCPs who provide additional services to assigned members. As applicable to the RAE, a PCMP is contracted with a RAE to participate in the Accountable Care Collaborative (ACC) as a network Provider and may be an MD, DO, or NP, and is a specialist in one of the following: family medicine, internal medicine, pediatrics, geriatrics, obstetrics and gynecology, community mental health center, HIV/infectious disease. PCMPs must provide definitive care to the undifferentiated patient at the point of first contact and take continuing responsibility for providing the patient's comprehensive care, with the majority of patient concerns and needs being cared for in the primary care practice itself. If recognized by an official entity, PCMPs shall provide copies of certification or accreditation as a patient-centered medical home (PCMH). Recognition, certification, or accreditation as a PMCH may be granted by any of the following entities:

- National Committee for Quality Assurance (NCQA)
- The Joint Commission
- Utilization Review Accreditation Commission (URAC)
- Accreditation Association for Ambulatory Healthcare (AAAHC)

Utilizer: A currently eligible member that has received a service resulting in a paid Medicaid

claim in the previous 18 months.