COLORADO ACCESS

ADMINISTRATIVE PAYMENT MODEL SPECIFICATION DOCUMENT

FY 2024-2025

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.

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) 24-25. Methodologies outlined in this document will be applicable to data collected during calendar year 2024.

Measurement Period:

The measurement period for baseline performance is based on prior calendar year claims data (2024).

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General FAQ:

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 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 2023) 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.

A1c Testing for Diabetics

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

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

Steward: NCQA

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 at the end of the measurement period who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year. Members with diabetes are identified through claim and pharmacy data. Members will be counted in the denominator if they are enrolled in the ACC on the last day of the measurement period.

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

Exclusions: 1) Members who did not have a diagnosis of diabetes in any setting, during the measurement period or the year prior ***and*** had a diagnosis of polycystic ovarian syndrome, gestational diabetes, or steroid induced diabetes in any setting during the measurement period or the year prior.

2) Members receiving hospice or palliative care any time during the measurement period.

3) Members who died 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.

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)[1]

Steward: NCQA

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. Members will be counted in the denominator if they are enrolled in the ACC on the last day of the measurement period.

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

Exclusions: Members who utilized hospice services or who died any time during the measurement period.

Additional Measure Stratification: N/A.

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

Answer: 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 2023), the attributed provider listed at the end of the measurement period would receive numerator credit.

[1] Center for Medicaid and CHIP Services. (January 2024). *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 2024 Reporting*. 133-134. medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf?t=1680036593

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)[1]
Contraceptive Care – Postpartum Women Ages 21-44 (CCP-AD)[2]

Steward: OPA

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 90 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. Members will be counted in the denominator if they are enrolled in the ACC on the last day of the measurement period.
2. **Were provided a long-acting reversible method of contraception (LARC) within three and 90 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. Members will be counted in the denominator if they are enrolled in the ACC on the last day of the measurement period.

Exclusions: Women with a live birth occurring after September 30th are excluded from the denominator because there may not have been an opportunity to provide the woman with contraception in the postpartum period (defined as within 90 days of delivery).

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

[1] Center for Medicaid and CHIP Services. (January 2024). *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 2024 Reporting*. 42-47. medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf?t=1680036593

[2] 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 2024 Reporting.* (January 2024). 48-53. medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf?t=1680036835

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.

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 during the last 3 months of the measurement period will be excluded from the denominator because they may not have an opportunity to receive contraception in the postpartum period (defined as within 90 days of delivery).

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

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. Members will be counted in the denominator if they are enrolled in the ACC on the last day of the measurement period.

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.

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.

Engagement Rate – All Population

Colorado Access Administrative Payment Model(s): All Models

HEDIS/Core Set Measure Name: N/A

Steward: COA

HEDIS Measure: No

CMS Core Set Measure: No

Measure Description: The percentage of attributed members for which the attributed PCMP site has submitted at least one claim in the previous calendar year (from any primary care site within the provider's tax ID).

Denominator: All attributed members. Members will be counted in the denominator if they are enrolled in the ACC on the last day of the measurement period.

Numerator: The number of members who had a professional claim with the attributed PCMP site.

Engagement Rate – Complex Members

Colorado Access Administrative Payment Model(s): Complex Member Model

HEDIS/Core Set Measure Name: N/A

Steward: COA

HEDIS Measure: No

CMS Core Set Measure: No

Measure Description: The percentage of attributed complex members for which the attributed PCMP site has submitted at least one claim in the measurement period (from any primary care site within the provider's tax ID).

Denominator: All attributed complex members. Members will be counted in the denominator if they are enrolled in the ACC on the last day of the measurement period.

Numerator: The number of complex members who had a professional claim with the attributed PCMP site.

Extended Care Coordination – Complex Members

Colorado Access Administrative Payment Model(s): Complex Member Model

HEDIS/Core Set Measure Name: N/A

Steward: HCPF with revisions by COA

HEDIS Measure: No

CMS Core Set Measure: No

Measure Description: Percentage of members identified as complex by COA who received extended care coordination within the measurement period.

Denominator: Members identified as complex by COA at any time during the measurement period. Members will be counted in the denominator if they are enrolled in the ACC on the last day of the last month of the 12-month measurement period. There is no continuous enrollment requirement for this measure.

Numerator: Number of members identified as complex by COA who received extended care coordination – a care plan or face to face visit with a care coordinator – within the measurement period. The codes for extended care coordination outreaches are:

- ECPA – Extended care plan activity
- EFTF – Extended face-to-face activity
- EOTH – Extended other activity

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)[3]
Asthma Medication Ratio: 19 to 64 (AMR-AD)[4]

Steward: NCQA

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.

Members will be counted in the denominator if they are enrolled in the ACC on the last day of the measurement period.

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.

[3] Center for Medicaid and CHIP Services. (January 2024). *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 2024 Reporting*. 30-36. medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf?t=1680036593

[4] 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 2024 Reporting.* (January 2024). 26-32. medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf?t=1680036835

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

- 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 or using hospice services any time during the measurement period.

4) Members who died any time during the measurement period.

Additional Measure Stratification: N/A

Medication Adherence – Diabetes

Colorado Access Administrative Payment Model(s): ECP Model

Measure Name: Proportion of Days Covered (PDC) Diabetes All Class

Steward: Colorado Access

HEDIS Measure: No

CMS Core Set Measure: No

Measure Description: The percentage of individuals with diabetes age 18 and older who met the PDC Diabetes All Class threshold of 80 percent during the measurement period.

Denominator: Members with diabetes age 18 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 with diabetes who met the PDC threshold of 80 percent during the measurement period.

Exclusions: Members with one or more prescription claim for insulin, members in hospice or receiving palliative care, members with end-stage renal disease, members who died any time during the measurement period.

Additional Measure Stratification: N/A

Overall Care Management Engagement Rate

Colorado Access Administrative Payment Model(s): ECP Model

HEDIS/Core Set Measure Name: N/A

Steward: COA

HEDIS Measure: No

CMS Core Set Measure: No

Measure Description: Percentage of Members who received deliberate or extended care coordination during the measurement period.

Denominator: All attributed members. Members will be counted in the denominator if they are enrolled in the ACC on the last day of the last month of the measurement period.

Numerator: Members who received a deliberate or extended care coordination outreach by their ECP at the TIN level within the measurement period.

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)[5]
Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)[6]

Steward: NCQA with revisions by COA

HEDIS Measure: No

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 during the measurement period.

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).

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.

Exceptions: Members who do not meet the numerator criteria and meets the following exception criteria will be removed from the denominator. However, if the Member meets the numerator criteria, the Member would be included in the measure denominator.

- Member refusal.

[5] Center for Medicaid and CHIP Services. (January 2024). *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 2024 Reporting*. 54-58. medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf?t=1680036593

[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 2024 Reporting.* (January 2024). 60-64. medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf?t=1680036835

- 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, functional, or motivational limitations 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 Administrative Payment Models 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:

- Referral to a practitioner for additional evaluation and assessment to formulate a follow-up plan for a positive depression screen,
- Pharmacological interventions, or
- Other interventions or follow-up for the diagnosis or treatment of depression.

Examples of qualifying follow-up plans include but are not limited to:

- 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.
- Other interventions designed to treat depression such as behavioral health evaluation, psychotherapy, pharmacological interventions, or additional treatment options.

The documented follow-up plan must be related to the positive depression screen.

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)[7]

Steward: NCQA

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 Model)**
   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. Per HEDIS General Guidelines, all events must be at least 14 days apart.
   Denominator: Children who turn 15 months old during the measurement period. Members will be counted in the denominator if they are enrolled in the ACC on the last day of the measurement period.
2. **Well-Child Visits for Age 15 Months to 30 Months (Pediatric and Family Medicine Models)**
   Numerator: Number of members who had two or more visits on different dates between the child's 15-month birthday and 30-month birthday. Per HEDIS General Guidelines, all events must be at least 14 days apart.
   Denominator: Children who turn 30 months old during the measurement period. Members will be counted in the denominator if they are enrolled in the ACC on the last day of the measurement period.

Exclusions: Members who utilized hospice services or who died any time during the measurement period.

Additional Measure Stratification: N/A.

[7] Center for Medicaid and CHIP Services. (January 2024). *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 2024 Reporting*. 125-127. medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf?t=1680036593

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.[8]

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

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

Answer: 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 2023), the attributed provider listed at the end of the measurement period would receive numerator credit.

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

Answer: Telemedicine options for children's well visits are not permitted beginning May 12, 2023, per Provider Bulletin 0423_B2300493. Any well visit code that HEDIS recognizes that has also been approved by Colorado Medicaid policy will be counted in this measure.

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.

[8] Colorado Department of Health Care Policy & Financing. (December 2022). *The Accountable Care Collaborative (ACC) Key Performance Indicators (KPI) Methodology SFY 2022-2023 Version 2.* 19-20.