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COLORADO ACCESS

PAY-FOR-PERFORMANCE PROGRAM DOCUMENT

ACC Phase 2

REWARDING PROVIDERS FOR MEETING REGIONAL GOALS

Introduction	Pay-for-performance is a program implemented by the Colorado Department of Health Care Policy and Financing (HCPF) that rewards payers and providers for achieving or exceeding pre-established benchmarks for quality of care, health results and/or efficiency. The HCPF pay-for-performance program supports the adoption of recommended guidelines to meet treatment goals for high-acuity conditions or preventive care.[1] Providers' clinical work and focus on their population's health outcomes directly impacts the regional success of these metrics. The Regional Accountable Entity (RAE) is responsible for the distribution of earned incentive dollars to the provider network. Provider payments are calculated based on methodologies developed collaboratively between Colorado Access and the RAE governing council. **Behavioral health partnership payments** are granted to the top 100 providers who provide the most behavioral health services in the region, based on claim volume. **Provider performance payments** are granted based on a provider's proportional contribution to a region meeting each metric. Performance payments follow slightly different models for different metrics. **Physical Health (PH) Panel performance payments** are granted based on the percentage of each primary care medical provider's (PCMP) attributed panel that was included in the numerator for the metric (example: percentage of members that received a dental service). Providers are then split into quartiles or tiers according to panel performance and dollars are split with higher performing practices receiving a larger share than lower performing practices. *Colorado Access extends its gratitude to its provider partners for their commitment to improving the health of their patients and all Coloradans.*

1: ncsl.org/research/health/performance-based-health-care-provider-payments.aspx

Key Performance Indicators Paid Quarterly	
Key Performance Indicator 1: Depression screen and follow-up plan • **Effective July 2023.**	Metric: Percentage of beneficiaries age 12 and older screened for depression on the date of the encounter, or 14 days prior to the date of the encounter, using an age-appropriate standardized depression screening tool, and, if positive, a follow-up plan is documented on the date of the eligible encounter. Calculation: Number of members age 12+ screened for depression using an age appropriate standardized tool with the appropriate G code documented, and if positive a follow plan is documented on the date of the encounter / number of members age 12+ with an outpatient visit during the measurement period Incentivized behavior: Screening, follow-up planning, and billing for depression screens. Payment methodology: 100% provider performance (Qualifying criteria – Limited to the top 90% of contributors).
Key Performance Indicator 2: Oral evaluation, dental services • **Effective July 2022.**	Metric: Percentage of Medicaid members younger than 21 who received a comprehensive or periodic oral evaluation. Calculation: Oral evaluation (%) = # Unique Members Younger Than 21 Who Received A Comprehensive Or Periodic Oral Evaluation / # Unique Members Younger Than 21 Enrolled in the ACC. Incentivized behavior: Screening, treatment and billing for dental health. Payment methodology: 50% provider performance; 50% panel performance* *Equal dollar amounts distributed to each tax ID within each quartile Quartile 1 = 50% Quartile 2 = 30% Quartile 3 = 20% Quartile 4 = Not eligible for payment
Key Performance Indicator 3: Child and adolescent well visits • **Effective July 2021.**	Metric: Medicaid members who received the appropriate minimum number of well visits based on their age and according to HEDIS standards within a 12-month evaluation period. Child and Adolescent Well Visit Part 1 (HEDIS W30): 1a. Children who had six or more well visits with a primary care

	provider on or before their 15-month birthday. 1b. Children who had two or more visits between the child's 15-month birthday and 30-month birthday. Child and Adolescent Well Visit Part 2 (HEDIS WCV): Children and adolescents with one or more well visits during the performance period. Incentivized behavior: Screening, treatment and billing for preventive care to attain and/or preserve overall good health. Payment methodology: 100% provider performance (top 90% of contributors). 50% paid according to provider performance on Well Visit Part 1 50% paid according to provider performance on Well Visit Part 2
Key Performance Indicator 4: Prenatal and postpartum care • **Effective July 2023.**	Metric: *Timeliness of Prenatal Care:* The percentage of deliveries in which women had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. *Postpartum Care:* Percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that had a postpartum visit on or between 7 and 84 days after delivery. Incentivized behavior: Timeliness of prenatal and postpartum care. Payment methodology: 50% based on prenatal performance; 50% based on postpartum performance Providers must contribute at least 0.5% numerator hits on one of the metrics to receive payment.
Key Performance Indicator 5: Emergency department visits (per thousand per year) risk adjusted • **Effective July 2021.**	Metric: Reduction of emergency department (ED) visits (per thousand per year). Lower rates are indicative of better performance. **Inclusion –** Practice sites must have 20 attributed diabetic and/or 20 attributed asthmatic members. **Exclusion –** ED visits that result in an inpatient admission. Incentivized behavior: Work with members who have diabetes and asthma to manage and control chronic illness to avoid ED visits for acute episodes. Work with members who visited the ED with acute exacerbations of diabetes and/or asthma to direct them to primary care when they encounter acute episodes. Ensure adequate walk-in or telehealth appointment availability.

	Payment methodology: 100% provider performance (providers performing at the *regional average or better).* 50% paid according to provider tier performance for asthma 50% paid according to provider tier performance for diabetes *Equal dollar amounts distributed to each tax ID within each tier Tier 1 = 50% Tier 2 = 30% Tier 3 = 20% Tier 4 = Not eligible for payment
Key Performance Indicator 6: Risk-Adjusted PMPM • **Effective July 2022.**	Metric: Risk adjustment is an algorithm that translates the health status of a person to a number, a risk score, to identify those that likely need more or fewer health care services and supports, as well as to predict healthcare costs. This measure represents the total cost of treating a population in a given time period expressed as a risk adjusted per member per month (PMPM) dollar amount. Calculation: *Weighted Population Average Risk Score* – Sum (Individual Risk Score * Individual Member Months) / sum (Individual Member Months). Total individual members only include those for members that have a risk score. This will be fewer than the member months used in the PMPM calculation since members cannot be retroactively eligible and receive a risk score. *Risk Adjusted PMPM* – PMPM / Population Average Risk Score Incentivized Behavior: Help members access appropriate primary care services and avoid unnecessary secondary and tertiary care services, to the extent possible. **Payment methodology**: 100% attribution

Behavioral Health Incentive Measures Paid Annually	
Behavioral Health Incentive Measure #1: **Initiation and Engagement of Substance Use Disorder Treatment** • **Effective July 2024**	Metric: Percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates reported. • Initiation of SUD Treatment. The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days • Engagement of SUD Treatment. The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation. Incentivized behavior: Timely and consistent treatment of patients with newly diagnosed substance use disorder. Payment methodology: Payment will be based on the Engagement of SUD Treatment Rate. 50% behavioral health partnership, 50% provider performance (qualifying criteria-top 100 providers by claim volume).
Behavioral Health Incentive Measure #2: **Follow-up appointment within 7 days of inpatient hospital discharge for mental health (MH) condition** • **Effective July 2021.**	Metric: Increase percentage of Health First Colorado members seen in an outpatient capacity by a mental health provider **within seven days of discharge** from an inpatient hospital episode (to the community or a non-24- hour monitored facility) for treatment of a primary covered mental health diagnosis. Incentivized behavior: Coordinated discharge planning between hospitals and outpatient providers to ensure timely follow-up. Payment methodology: 50% BH partnership, 50% provider performance (qualifying criteria - top 100 providers by claim volume).
Behavioral Health Incentive Measure #3: **Follow-up appointment within 7 days of an emergency department (ED) visit for a substance use disorder (SUD)** • **Effective July 2021.**	Metric: Increase the percentage of members who were seen in an outpatient capacity by a behavioral health provider **on or within seven days of discharge** from an emergency department episode (to the community or a non-24-hour treatment facility) for treatment of a covered SUD. Incentivized behaviors: Coordinated discharge planning between hospitals and outpatient providers to ensure timely follow-up. Payment methodology: 50% BH partnership, 50% provider performance (qualifying criteria - top 100 providers by claim volume).

Behavioral Health Incentive Measure #4: **Follow-up after positive depression screening** • **Effective July 2024.**	Metric: Increase percentage of Health First Colorado members engaged in a mental health service **on or within 30 days** of screening positive for depression within a primary care setting. **This measure includes a qualifying gate measure prior to achieving eligibility for incentive dollars. The gate measure requires each region to conduct depression screens on a minimum percentage of patients. Depression screening rates must *increase by a 10% gap closure* between RAE performance and the department goal. Incentivized behaviors: (1) Depression screening and proper billing (G8431 orG8510) in primary care. (2) Coordination between primary care providers and behavioral health providers to ensure timely follow-up after a positive screen. Payment methodology*:* 100% provider performance for timely follow-up visits. (Qualifying criteria - minimum 0.50% contribution to region meeting the metric).
Behavioral Health Incentive Measure #5: **Behavioral health screening or assessment for children in the foster care system** • **Effective July 2021.**	Metric: Increase percentage of Health First Colorado foster care children who received a behavioral health screening or assessment **on or within 30 days** of entering the foster care system/RAE enrollment. Incentivized behaviors: Timely behavioral health screening for all foster children. Payment methodology: 50% BH partnership, 50% provider performance. (All contributors)

Performance Pool Paid Annually beginning in 2025	
Performance Pool Indicator #1: Extended care coordination • **Effective July 2021.** • **First payment estimated in 2025.**	Metric: Percentage of members with complex needs who received extended care coordination within the performance period Numerator: Members identified as complex on day one of the performance period under a new definition are expected to have a robust care plan developed within the first 120 days. • Members identified as complex at any time after day one of the performance period are expected to a robust care plan developed within 90 days of the member being identified as complex. • Members who were identified as complex under the old definition and remain in the complex population under the new definition, who have an active care plan DO NOT require development of a new care plan. These members are expected to have bi-directional contact with the care coordinator in the 90 days prior to day one of the new definition. • All members engaged in extended care coordination are expected to have, at minimum, quarterly bidirectional contact with the member by the care coordinator. The following members can be counted in the numerator of the metric, but must be reported separately: • Members who are "**unreachable**" can be counted in the numerator, as long as they received at least three outreach attempts with two different modalities based on what is deemed by the care coordination team to be most effective for successful engagement and keeping in mind any limits to the availability of contact information. Members who are unreachable must have an attempted outreach every six months after the initial attempt is made. • Additionally, members who **opt-out** of extended care coordination can also be counted in the numerator. RAEs must have in place a documented opt-out process for members. Members who opt-out must have an attempted outreach every six months after the initial attempt is made.

	• The opt-out process can include members who have been in extended care coordination but **met their goals** and no longer need or want support. If a member's lead care coordinator is a case management entity or another organization, the member can still be counted in the numerator, as long as the RAE care coordinator has an up-to-date care plan on file and meets the quarterly bidirectional contact requirement by the RAE care coordinator. <u>Denominator:</u> Number of members with complex needs, identified at any time during the performance period. There is no continuous enrollment requirement. The look-back period will be 24 months long plus three additional months of claims run-out. <u>Incentivized behavior</u>: Members with complex conditions may require more intense levels of care coordination, or they may need more frequent care management contacts to properly address their condition. <u>Payment methodology</u>: There are three site level threshold criteria required to become eligible for the proportional contribution and accountability parts of ECC payment: 1) Case review score of 36/42 or higher, 2) Contribute at least .5% to total regional ECC numerator, and 3) Engage at least 25% of complex members in ECC. TINs that didn't qualify for proportional contribution or accountability payments are eligible for the equity investment. Payment for each RAE will be calculated separately and as follows: • <u>Proportional Contribution:</u> The percentage of ECC numerator contribution at TIN level toward the total regional ECC numerator and is worth 60% of ECC regional total payment. Example – A TIN contributes 25% of the regional ECC numerator. Proportional Payment = .25 x .60 x total regional ECC payment • <u>Accountability Contribution:</u> – The percentage of attributed complex members engaged in ECC at the TIN level is worth 30% of ECC regional total payment. Payment is broken down into three tiers. Top performing tier receives 50%, middle tier receives 30% and bottom tier receives 20%. The number of TINS in each tier will be determined by Colorado Access. Example – Payment for a TIN in the top performing tier = .50 x .30 x total regional ECC payment

	• Equity Investment – Reserved for TINs that did not have at least one site achieve all three threshold criteria and is worth 10% of the ECC regional total payment. Payment is based on the percentage of complex members engaged in ECC. Example – A TIN had 25% of complex members within the TINs that qualified for the equity investment payment. Equity Investment = .25 x .10 x total regional ECC payment
Performance Pool Indicator #2: Premature birth rate • **Effective July 2021.** • **First payment estimated in 2025.**	Metric: Number of premature births (< 37 weeks) per total live births within the performance period Numerator: Number of premature births (<37 weeks) within the performance period. Denominator: Number of total live births within the performance period. Incentivized behavior: Incentivize preventable preterm births. Payment methodology: 50% based on prenatal KPI performance; 50% based on postpartum KPI performance
Performance Pool Indicator #3: Behavioral health engagement for members releasing from state prisons • **Effective July 2021.**	Metric: Percentage of members releasing from a Department of Corrections (DOC) facility with at least one billed behavioral health capitated service or short-term behavioral health visit within fourteen days. Numerator: Number of members who had at least one billed behavioral health capitated service or short-term behavioral health visit within fourteen days of being released from a DOC facility. Denominator: Number of members who were released from a DOC facility and who are eligible for Medicaid. Incentivized behavior: Incentivizes behavioral health providers to engage with Medicaid recipients releasing from state prisons with behavioral health disorders. Payment methodology: Targeted providers may receive a one-time upfront payment to support program operations and cover costs of non-billable activities such as transportation of members to parole appointments, meeting with members while they are still incarcerated,

	attending parole office meetings and driving to prisons in rural parts of Colorado. Targeted providers may earn quarterly performance incentives based on the percentage of successful outreach efforts that convert into billed Fee-For-Service (FFS) claims for behavioral health services within 14 days of release (attribution model).
Performance Pool Indicator #4: Asthma medication ratio • **Effective July 2021.** • **First payment estimated in 2025.**	Metric: 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. 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. 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. Incentivized behavior: Medication adherence aligns with Colorado Access and the Department's focus on chronic condition management and support for members. Payment methodology: TBD
Performance Pool Indicator #5: Antidepressant medication management • **Effective July 2021.**	Metric: Percentage of members age 18 and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported:

	Effective *Acute* Phase Treatment: Percentage of beneficiaries who remained on an antidepressant medication for at least 84 days (12 weeks). Effective *Continuation* Phase Treatment: Percentage of beneficiaries who remained on an antidepressant medication for at least 180 days (6 months). Numerator (Effective Acute Phase Treatment): Members who had at least 84 days (12 weeks) of treatment with antidepressant medication beginning on the index prescription start date through 114 days after. Denominator (Effective Acute Phase Treatment): Members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Numerator (Effective Continuation Phase Treatment): Members who had at least 180 days (6 months) of treatment with antidepressant medication beginning on the index prescription start date through 231 days after. Denominator (Effective Continuation Phase Treatment): Members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Incentivized behavior: Medication adherence aligns with Colorado Access and the Department's focus on chronic condition management and support for members. Payment methodology: TBD
Performance Pool Indicator #6: Contraceptive care for postpartum women • **Effective July 2021.** • **First payment estimated in 2025.**	Metric: Among women ages 15 through 44 who had a live birth, the percentage that is provided: 1) A most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately (i.e., injectables, oral pills, patch, ring, or diaphragm) effective method of contraception within three and 90 days of delivery. 2) A long-acting reversible method of contraception (LARC) within three and 90 days of delivery. Numerator (most/moderate effective contraception): The eligible population that was provided a most or moderately effective method of contraception.

	Denominator (most/moderate effective contraception): 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. Numerator (LARC): The eligible population that was provided a LARC method. Denominator (LARC): 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. Incentivized behavior: Reduction of rapid repeat births Payment methodology: 100% based on postpartum KPI performance