COLORADO ACCESS

FAMILY MEDICINE ADMINISTRATIVE PAYMENT MODEL PROGRAM

FY 2022-23 PROGRAM DOCUMENT

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 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, 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 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.

II. Evolution of COA's Administrative Payment Model Program:

Phase 1: The first phase of the COA Administrative Payment Model (APM) was the implementation of a $3.00 per member per month payment that incentivizes providers to open their panels to Health First Colorado members, allowing all members to be assigned to a medical home. This phase was in place from July 1, 2018, through December 31, 2020.

Phase 2: The second phase of the COA Administrative Payment Model includes the introduction of member classifications: **utilizers**, **non-utilizers,** and **complex members**.

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[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.

The utilizer per member per month (PMPM) payment was based on a provider's proportional engagement with their attributed member panel (**engagement rate score**) as well as the presence of medical home best practices, as outlined in Addendum 1 of the PCMP contracts (**practice assessment score**). These two scores blended to determine a provider site's utilizer PMPM payment. A $0.50 PMPM add-on payment to the utilizer PMPM was awarded to all providers that participated in the Department of Health Care Policy & Financing's (HCPF) Alternative Payment Model program. The non-utilizer is a member that has not utilized Medicaid services in the previous 18 months. The non-utilizer rate was established at $0.50 PMPM.

The **PCMP+ provider tier** was introduced in Phase 2. These are providers who perform well on engagement rate and practice assessment scores and demonstrate clinical and reporting capabilities to care manage their attributed complex members. PCMP+ and Enhanced Clinical Partner (ECP) providers additionally send a summary of their care management activities to the RAE in the required report format. Both providers received a base $5.00 PMPM for all attributed complex members and an additional PMPM payment for each complex member they engaged within the previous 12 months (**complex claims engagement rate**). This phase of the model was in place from January 1, 2021 through June 30, 2021.

Phase 2.5: This phase largely carried over the elements from Phase 2. The utilizer PMPM continued to be determined by provider performance on **engagement rate** and **practice assessment scores**. Impacts on attribution and member utilization behaviors caused by COVID-19 were addressed, and performance expectations were decreased for engagement rate scores.

Colorado Access chose to retire the $0.50 PMPM add-on payment for participation in HCPF's APM program and replaced it with its own pay for participation program, **Controlled Chronic Conditions: Emergency Department Reduction Program (C^{3}EDR).** This program incentivizes the use of registry, claims or EHR data to identify and prioritize members that are most in need of help with managing their diabetes, asthma, and/or COPD. It also incentivizes the implementation of intervention programs that are aimed at helping members achieve control of their chronic condition(s) with the goal of keeping them out of the emergency department (ED). Participating providers received $0.50 PMPM for participation in this program. The program was optional for PCMPs and PCMP+s with 200 or more attributed members and practice sites that participate in HCPF's APM program. Program participation was required for ECPs. As of May 1, 2022, all eligible sites have been enrolled into the C^{3}EDR Program. For a list of participating sites, please email practice_support@coaccess.com. More information about this

program can be found at coaccess.com/providers/resources/vbp. The C^{3}EDR Program is effective through June 30, 2023.

The Complex PMPM payment was also adjusted to a performance-based payment determined by the blending of two metrics: **complex claims engagement** and **complex extended care coordination**. More weight is given to the complex extended care coordination (ECC) metric, as this payment is intended to incentivize care planning activities. Complex ECC is defined as the percentage of attributed complex members who received ECC in the previous 12 months. The complex PMPM payment is tiered by performance and paid to PCMP+ and ECP sites.

The **ECP assessment** was introduced in Phase 2.5 of the model and was comprised of two parts: Addendum 2 compliance and case reviews. The Addendum 2 compliance component assesses ECPs' abilities in quality improvement, population management and care management activities. Case reviews assess five patients' individualized care plans for presence of evidence-based best practices associated with the patients' diagnoses.

This version of the Administrative Payment Model is effective July 1, 2021, through June 30, 2022.

Phase 3: Colorado Access will adjust the model in July 2022 to build upon the progress achieved during Phases 2 and 2.5 in incentivizing improved health outcomes for Health First Colorado members. Phase 3 focuses on obtaining provider data that demonstrates success with chronic disease management across the providers' attributed population (e.g., HgA1c testing, medication adherence, etc.). It also incentivizes behaviors that demonstrate best practices in preventive care (e.g., well-visits, depression screening, etc.).

Colorado Access recognizes that the PCMP provider network is diverse with various provider types (i.e., reproductive health, pediatrics, internal medicine, and family medicine) and therefore includes providers with different levels of resources and experience with chronic disease management, prevention, and population health management best practices. For this reason, COA has chosen to develop different payment models for these provider types to better measure the scope of care received by Health First Colorado members. These models are effective on July 1, 2022.

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.

III. All-Network Provider Site Payments:

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

- Utilizer payment
- C^{3}EDR Program add-on payment
- Non-utilizer payment
- KPI incentive payment

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, while new measures are in blue.

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) **A1c testing for diabetics 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 2021). 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 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		Practice Assessment Score	
0-12%	0	0-90%	0
13-25%	1	91-93%	1
26-40%	2	94-96%	2
41-56%	3	97-100%	3
57-100%	4		

Score Determines PMPM Payment

0 = $0 **1-2 =$0.50** **3-5 = $0.75** **6-7 = $1.00**

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. Up to an additional $1.00 PMPM will be added to the site's utilizer payment depending on provider performance. Scoring and associated PMPM payment is demonstrated in Figure 2.

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

Depression Screen (Engaged Members Only)	
0-8%	0
9-15%	1
16-30%	2
31-49%	3
50-100%	4

Score Determines PMPM Payment

0-1 = $0.25 **2-3 = $0.75** **4 = $1.00**

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 their 15-month birthday, calculated as a percentage of the site's attributed membership that turned 15 months old during the measurement period. Up to an additional $1.00 PMPM will be added to the site's utilizer payment depending on performance. Scoring and associated PMPM payment is demonstrated in Figure 3.

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 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.

Child and Adolescent Well Care Visits. The total number of unique attributed members ages 3 to 21 who received one or more well visits, calculated as a percentage, of the site's attributed membership during the measurement period. Up to an additional $1.00 PMPM will be added to the site's utilizer payment depending on performance.

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

Well-Visits Within the First 15 Months of Life	
0-25%	0
26-33%	1
34-51%	2
52-69%	3
70-100%	4

Score Determines PMPM Payment

0 = $0.25 **1-2 = $0.75** **3-4 = $1.00**

Sites without 10 attributed members during the measurement period:

Child and Adolescent Well-Care Visits	
0-16%	0
17-25%	1
26-40%	2
41-55%	3
56-100%	4

Score Determines PMPM Payment

0 = $0.25 **1-3 = $0.75** **4 = $1.00**

A1c Testing for Diabetics. The total number of unique members with type 1 or type 2 diabetes who received one A1c test during the measurement period. Tests administered via an emergency and inpatient visit are included in this metric. Up to an additional $1.00 PMPM is available for sites to earn based on their performance. Scoring and associated PMPM payment is demonstrated in Figure 4.

Figure 4: Utilizer Payment – A1c Testing for Diabetics PMPM Scoring Criteria

A1c Testing for Diabetics	
0-46%	0
47-59%	1
60-69%	2
70-79%	3
80-100%	4

Score Determines PMPM Payment

0 = $0.25 **1-3 = $0.75** **4 = $1.00**

Payment #2 – C^{3}EDR Program Add-on Payment. An additional $0.50 PMPM will be added to the utilizer payment for all practice sites that participate in the COA Controlled Chronic Conditions: ED Reduction (C^{3}EDR) Program. This add-on payment is only applicable to members classified as utilizers. Additional information about this program can be found online at coaccess.com/providers/resources/vbp.

Eligibility Criteria for C^{3}EDR Program: Provider practice site must have a minimum of 200 attributed members to participate in this program. Eligible PCMPs and PCMP+s may choose to opt-out of this program. ECPs are **required** to participate in this program and will automatically be enrolled and allotted the $0.50 PMPM add-on payment.

Payment #3 – Non-Utilizer Payment. Providers will receive $0.50 PMPM for members classified as non-utilizers.

IV. Key Performance Indicator (KPI) Payments

Payment #4 – KPI Incentive Payment. KPI 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.

Utilizer, C³EDR Program add-on, and non-utilizer payment example:

Provider X has a total attributed membership of 2,000 at the end of December 2021, with the minimum number of eligible members for the Well Visits 0 to 15 Months of Life metric. Provider X has additionally opted into the COA C³EDR program.

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 the diabetic members received a yearly A1c test.

Utilizer Payment (Payment #1):

Engagement Rate (57%) + Practice Assessment Score (89%) = 4 points; $0.75 PMPM
Screening for Depression (21%) = 2 points; $0.75 PMPM
Well Visits 0 to 15 Months (72%) = 4 points; $1.00 PMPM
A1c Testing for Diabetics (47%) = 1 points; $0.50 PMPM

Total Score of 11 = $3.00 PMPM

$3.00 PMPM (**Payment #1**) + $0.50 PMPM for C³EDR Program participation (**Payment #2**), therefore,

Provider X receives $3.50 PMPM for all utilizers
Provider X receives $0.50 PMPM for all non-utilizers (**Payment 3**)

Monthly Payment = ($3.50 * 1,900 Utilizers) + ($0.50 * 100 non-utilizers)
= **$6,700.00**

Utilizer, C³EDR Program add-on, and non-utilizer payment example cont.:

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 2021, without the minimum number of eligible members for the Well Visits 0 to 15 Months of Life metric. Provider X has additionally opted into the COA C³EDR program.

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 age 3 to 21 received one or more well visits during the year.

Utilizer Payment (Payment #1):

Engagement Rate (57%) + Practice Assessment Score (89%) = 4 points; $0.75 PMPM
Screening for Depression (21%) = 2 points; $0.75 PMPM
Child and Adolescent Well-Visits Age 3-21 (57%) = 4 points; $1.00 PMPM

Total Score of 12 = $2.50 PMPM

$2.50 PMPM (**Payment #1**) + $0.50 PMPM for C³EDR Program participation (**Payment #2**), therefore,

Provider X receives $3.00 PMPM for all utilizers

Provider X receives $0.50 PMPM for all non-utilizers (**Payment 3**)

Monthly Payment = ($3.00 * 1,900 Utilizers) + ($0.50 * 100 non-utilizers)

= **$5,750.00**

V. 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 #5 – 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 in Addendum 1 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 5.

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 5: Complex Member Payment - Complex Member PMPM Scoring Criteria

Complex Claims Engagement Rate		Complex Extended Care Coordination Rate	
0-50%	0	0-10%	0
51-65%	1	11-25%	1
66-84%	2	26-49%	2
85-100%	3	50-100%	3

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%) = 2 points

Total Score of 4 = $10.00 PMPM

$10.00 PMPM (**Payment 5**) * 100 complex members, therefore

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

VI. 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 #6 – 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 ECP's 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. Measures carried over from previous models are denoted in black, while new measures are in blue.

Care Plan Score. The Care Plan component of the COA ECP assessment is a review of a practice's submission of five 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 6: ECP Care Management Payment - PMPM Scoring Criteria

Care Plan Score		Unlimited Panel Score		Overall Care Management Engagement Rate	
0-89 points	0	No	0	0-10%	0
90-97 points	1	Yes	1	11-25%	1
98-100 points	2			26-40%	2
				41-55%	3
				56-100%	4

Score Determines PMPM Payment

0-3 = $2.50 **4-5 = $3.00** **6-7 = $3.50**

Payment #7 – 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 and/or diabetes, Figure 7. **Practices must have at least 20 attributed asthmatic and/or 20 attributed diabetic members to qualify for this payment.** This add-on payment will be added to the ECP Care Management Payment (**Payment 6**).

Figure 7: ECP Care Management Payment – Medication Adherence Add-on PMPM Scoring Criteria

Asthma Medication Adherence		Diabetes Medication Adherence	
< 60%	0	< 80%	0
≥ 61%	1	≥ 81%	1

Score Determines PMPM Payment

0 = $0.00 **1 = $0.50** **2 = $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 and 55% of their diabetic members compliant with their medication(s).

ECP Care Management Payment (Payment #6):

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

Diabetes Medication Adherence (55%) = 0 points; $0.00 PMPM

Total Score of 1 = $0.50 Add-on PMPM

$2.50 PMPM (**Payment #6**) + $0.50 PMPM for Medication Adherence performance (**Payment #7**), therefore Provider Y receives **$3.00 PMPM**.

Monthly Payment = $3.00 PMPM * 100 members

= **$300.00**

VII. 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 member.

Complex Claims Engagement Rate. The percentage of attributed complex members who had a claim with one of the ECPs or 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.

Controlled Chronic Conditions ED Reduction Program (C3EDR). A program that requires providers to implement an intervention to reduce emergency department visits by working to improve patients' control of their chronic diabetes, asthma and/or COPD.

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. 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 the

State 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.

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 M.D., D.O., or a N.P., 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 PCMH 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.