COLORADO ACCESS

REPRODUCTIVE HEALTH ADMINISTRATION PAYMENT MODEL

FY 2024-25 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 (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 method that delivers the highest quality of primary care for patients with one or more chronic conditions.[1] Preliminary evidence also shows that the PCMH model produces better clinical outcomes, higher adherence, and lower emergency department utilization for low-income populations.[2]

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 two potential payments that all PCMPs may receive under Addendum 1:

- Utilizer payment
- KPI and Performance Pool incentive payments

A site's overall utilizer payment is determined according to their performance on metrics

[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.

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 four metrics which make up the utilizer payment. Additionally, all provider site types are eligible to receive the three 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 four metrics: 1) **engagement rate score,** 2) **screening for depression score,** 3) **contraceptive care – postpartum women score,** and 4) **contraceptive counseling – all women ages 15 to 44 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 2023). Scoring and associated PMPM payment is 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.

Figure 1: Utilizer Payment – Engagement Rate PMPM Scoring Criteria

Engagement Rate			
Lower Bound	**Upper Bound**	**Level**	**PMPM Amount**
0%	18%	Min	$0.00
19%	55%	Mid	$0.25
56%	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

Depression Screen Age 12+ (Engaged Members)			
Lower Bound	**Upper Bound**	**Level**	**PMPM Amount**
0%	4%	Min	$0.50
5%	38%	Mid	$1.00
39%	100%	Max	$1.25

Contraceptive Care – Postpartum Women. Among attributed women members ages 15 to 44 who had a live birth, the percentage of members who were provided a most or moderately effective method of contraception. The Contraceptive Care – Postpartum Women and Contraceptive Counseling scores are blended as demonstrated in Figure 3.

Note: COA does not expect performance to reach 100% for the Contraceptive Care – Postpartum Women metric, 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.

Contraceptive Counseling – All Women Ages 15-44. Among attributed women members ages 15 to 44, the percentage of members who received contraceptive counseling. Scoring and associated PMPM payment is demonstrated in Figure 3 on pages 5-6.

Figure 3: Utilizer Payment – Contraceptive Care – Postpartum Women and Contraceptive Counseling PMPM Scoring Criteria

Postpartum 90-Day Contraception		
Lower Bound	**Upper Bound**	**Points**
0%	28%	1
29%	32%	2
33%	100%	3

Contraceptive Counseling		
Lower Bound	Upper Bound	Points
0%	10%	1
11%	32%	2
33%	100%	3

Score Determines PMPM Payment

1-2 = $0.50 **3-5 = $1.25** **6 = $2.00**

Utilizer Payment Example:

Provider X has an attributed membership of 1,900 at the end of December 2023.

Provider X received a 26% engagement rate. They screened 40% of their engaged members for depression, 22% of postpartum women received a most or moderately effective method of contraception, and 18% of women ages 15 to 44 received contraceptive counseling.

Utilizer Payment (Payment #1):

Engagement Rate	(26%)	= $0.75 PMPM (Mid Level)
Screening for Depression	(40%)	= $1.50 PMPM (Max Level)
Contraceptive Care – Postpartum Women	(22%)	= 1 Point
Contraceptive Counseling	(18%)	= 2 Points
		= $1.25 (3 Points)
		= $3.50 PMPM

Monthly Payment = ($3.50 * 1,900 Utilizers)
= **$6,650.00**

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

Payment #2 – 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 and meet clinical metrics. 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 #3 – 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.

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 will be 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%	52%	0
53%	65%	1
66%	85%	2
86%	100%	3

Complex ECC Rate		
Lower Bound	**Upper Bound**	**Points**
0%	13%	0
14%	29%	2
30%	55%	4
56%	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
		= $10.00 PMPM (6 points)

Monthly Payment = $10.00 PMPM (**Payment #3**) * 100 complex members

= **$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 #4 – 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 5. 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 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 the Department's records. Practice panel status can be verified or changed by emailing the practice support team at practice_support@coaccess.com upon request.

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	41	1
42	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%	24%	1
25%	81%	2
82%	100%	3

Score Determines PMPM Payment

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

Payment #5 – 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 intheir attributed Members with asthma and/or diabetes, Figure 6. **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.

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

Asthma Medication Ratio			
Lower Bound	Upper Bound	Level	PMPM Amount
0%	64%	None	$0.00
65%	100%	Max	$0.50

Diabetes Medication Adherence			
Lower Bound	Upper Bound	Level	PMPM Amount
0%	75%	None	$0.00
76%	100%	Max	$0.50

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 37 on their care plan reviews and has engaged 14% of their attributed membership with care management. Provider Y has additionally kept 65% of their asthmatic members and 55% of their diabetic members compliant with their medication(s).

ECP Care Management Payment (Payment #4):

Care Plan Score	(37 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 #5):

Asthma Medication Ratio	(66%)	= $0.50 PMPM (Max Level)
Diabetes Medication Adherence	(55%)	= $0.00 PMPM (None Level)

= $0.50 Add-on PMPM

$2.50 PMPM (**Payment #4**) + $0.50 PMPM (**Payment #5**) = **$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 member.

Complex Claims Engagement 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. 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, 2023, the measurement period is calendar year 2022.

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.

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 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.